Proposal for a Section 1915(b)
Primary Care Case Management (PCCM) Waiver Program
Waiver Renewal Submittal

State of Idaho

June 2002

US DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Care Financing Administration
Center for Medicaid and State Operations

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PROPOSAL FOR A SECTION 1915(b)
PRIMARY CARE CASE MANAGEMENT (PCCM) WAIVER PROGRAM
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Introduction

Idaho's PCCM waiver program, Healthy Connections, began in 1993 and has remained virtually unchanged since its beginning. The program has striven to remain as simple as possible and follows the goals of:

- Ensure access to health care
- Provide health education
- Promote continuity of care
- Strengthen the physician/patient relationship
- Achieve cost efficiencies

Idaho Medicaid is in the process of changing from a claims-based focus to a care management focus. This year, the Idaho legislature approved a supplemental budget request to increase the program's staff size (10 new positions). There are now 14 Healthy Connections Representatives (HCR) placed in the 7 regions of Idaho. The HCRs serve as enrollment brokers for the program as well as the liaison for resolving program issues between providers and clients. They also have the primary responsibilities for PCP recruitment/retention, identifying barriers to and resolving issues around provider participation.

Within the next waiver period, Idaho hopes to significantly increase program participation throughout the state. To this end, the program will be attempting to make client participation mandatory in as many areas of Idaho as possible. While access to primary care providers (who also serve as PCCMs) will be key to the success of these enrollment efforts, educational components, as well as a disease management component, will also be implemented to further enhance the effectiveness of the program in achieving cost efficiencies.

Other issues that will be addressed in the next waiver period are:

- Full incorporation and further implementation of the pending BBA rules
- Evaluation of moving the program to State Plan option
- Incorporation of rules and regulations that will move the State into HIPAA compliance
- Evaluation of enhanced case management fees for PCPs who achieve and maintain high levels of quality care to patients as benchmarked against peers

To achieve goals in access and customer education, Idaho has contracted with Americorp to provide for 14 VISTA volunteers throughout the state. This group has been conducting PCP

surveys in conjunction with the Division of Health's Bureau of Primary Care to collect needed data to ascertain health care professional shortage areas and overall access for Medicaid clients. The VISTAs will be moving focus to further development of the client education component for the Medicaid program. Additionally, VISTAs work closely with community partners in conducting CHIP outreach/education and will aid in conducting focus studies on targeted issues.

The recent economic downturn has emphasized the need to fully explore programs that demonstrate cost-effectiveness. Healthy Connections has historically demonstrated that by providing access to care at the right place and time reduces utilization of more costly services.

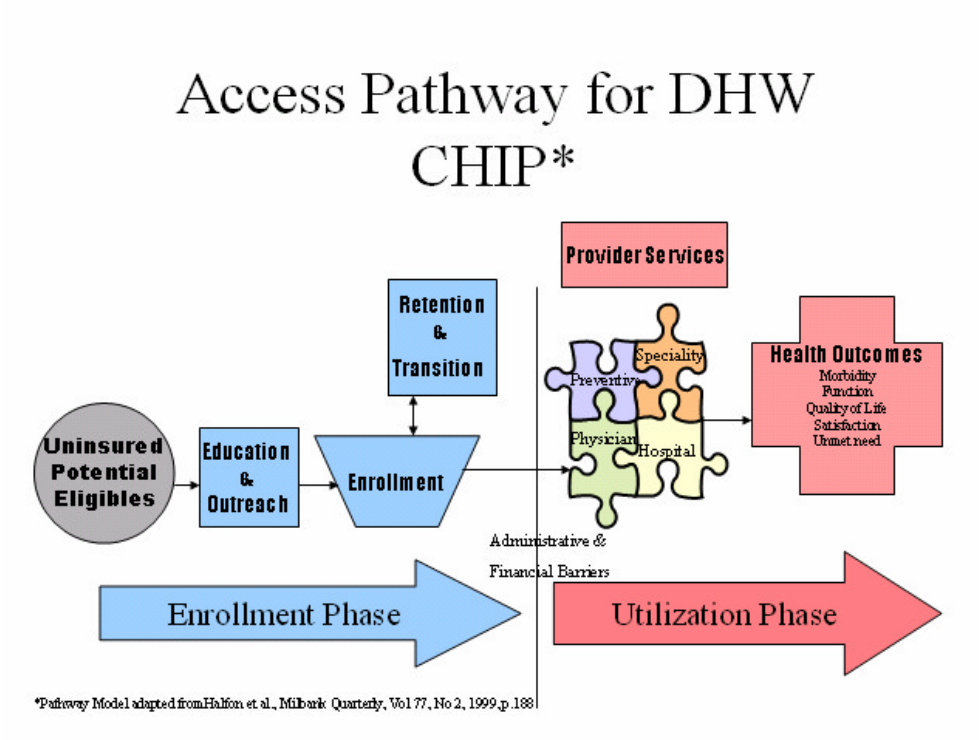
Section A. General Impact

I. Background

[Required] *Please provide a brief executive summary of the State's 1915(b) waiver program's activities since implementation, including experiences during the previous waiver period(s) and a summary of any program changes either planned or anticipated during the requested renewal period. Please specify the types of stakeholders or other advisory committee meetings that have occurred in the previous waiver period or are expected to occur under the future waiver period. Please include descriptions of any advisory boards that have consumer representation. In addition, please describe any program changes and/or improvements that have occurred as a result of stakeholder involvement during the previous waiver period(s). Please describe any stakeholder involvement in monitoring of the previous waiver period. Finally, to the extent the State enrolls persons with special health care needs, please describe how the various stakeholders have been involved in the development, implementation, and ongoing operation of the program.*

Idaho's Medicaid managed care program, Healthy Connections, was implemented in 1993 as a primary care case management (PCCM) model of coordinated care that is still in effect today. Inherit to Idaho's PCCM program is the medical home model of primary health care delivery where doctors and patients "team up" and work together in producing positive outcomes to health/medical issues.

With implementation of the Children's Health Insurance Program (CHIP) in Idaho as a Medicaid expansion, began adoption of the Halfon pathway model (see below). In this model, outreach/education efforts naturally lead to focus on access issues which have remained core of the Healthy Connections program to date.



Dedicated to delivering "The right service at the right time in the right place for the right price", Idaho has begun adding resources to address access and education issues to the Medicaid-covered service delivery system. Healthy Connections staff were doubled in spring of 2002 to accommodate the statewide initiative to move the program from a mostly voluntary to a primarily mandatory program statewide. A significant component of the educational piece will be development of a disease management program with peer-grouping feedback to primary care providers.

In conjunction with Welfare reform efforts to delink Medicaid from other Welfare programs, Idaho has striven to promote simplified access to Medicaid programs and providers by choosing not to carve populations out of the waiver program. This strategy increases the overall access to primary care providers for individuals dependent on Medicaid purchased services by decreasing fragmentation of client populations served and has historically worked well in Idaho since initiation of the waiver program. Special populations, such as children with special health care needs, are served by the same set of providers as all other individuals in Idaho. The liaison function of the HCRs provides a vital link between PCPs and other service providers to serve these populations under the waiver program.

II. General Description of the Waiver Program

Previous Waiver Period

a.___ During the last waiver period, the program operated differently than described in the waiver governing that period. Please explain why the program operated differently and what the differences were:

Upcoming Waiver Period -- *For items a. through m. of this section, please identify any responses that reflect a change in program from the previous waiver submittal by placing two asterisks (i.e., "**") after your response.*

A. ***The State of*** **___Idaho____** requests a waiver under the authority of section 1915(b)(1) of the Social Security Act (the Act). The waiver program will be operated directly by the Medicaid agency. The Bureau of Medicaid Benefits & Reimbursement Policy administers the program.

B. ***Effective Dates:*** This waiver is requested for a period of 2 years; effective **August 8, 2002**___ and ending **August 7, 2004**__.

C. ***The waiver program is called*** **__Healthy Connections**

D. ***Geographical Areas of the Waiver Program:*** Please indicate the area of the State where the waiver program will be implemented. (Note: If the State wishes to alter the waiver area at any time during the waiver period, an official waiver modification request must be submitted to HCFA):

1. Statewide __XX____; or

2. Other, please list the areas, counties, and/or regions of the State:

City	County	Region

E. ***State Contact:*** The State contact person for this waiver is Robin Pewtress and can be reached by telephone at (208) 364-1892___.

F. ***Statutory Authority:*** The State's waiver program is authorized under ***Section 1915(b)(1) of the Act***, which provides for a primary care case management (PCCM) system or specialty physician services arrangement under which the State restricts the provider from or through whom a recipient can obtain medical care.

G. ***The State is also relying upon authority provided in the following section(s) of the Act:***

1. __X__ ***1915(b)(2)*** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among Primary Care Providers (PCP) in order to provide recipients with more information about the range of health care options open to them.

   If you checked #1 above, please specify who will be acting as the locality's broker, how this entity will be chosen by the State and explain in detail how this arrangement will work (refer to Section 2105 of the State Medicaid Manual).

Health Resource Coordinators (formerly known as Healthy Connection Representatives) are employees of the Department of Health and Welfare (DHW) and are responsible for explaining the HC Program to eligible clients and for enrolling and disenrolling clients. These employees (currently 14) are located throughout the State in the Department's Regional Medicaid Services Units. These units conduct operational duties associated with Idaho Medicaid's waiver programs. Additionally, there are currently two HRCs located in Central Office that serve as back-up to the regional HRCs.

2. ___ ***1915(b)(3)*** - The State will share cost savings resulting from the use of more cost effective medical care with beneficiaries by providing them with additional services.

   If you checked #2 above, please note the additional services to be provided under the waiver which are not covered under the State plan.

3. ___ ***Other Statutes utilized*** - Please list any additional Section(s) of the Act the State requests to utilize, including an explanation of the request. For example, 1915(b)(4) authority is needed if the State

wishes to choose only a subset of qualified providers to serve the waiver population.

H. Relying upon the authority of the above Section(s), the State would like a waiver of the following Sections of 1902 of the Act:

1. ___ ***Section 1902(a)(1)*** - Statewideness--This Section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

2. _X_ ***Section 1902(a)(10)(B)*** - Comparability of Services--This Section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid recipients not enrolled in the waiver program.

3. _X_ ***Section 1902(a)(23)*** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, individuals enrolled in this program are constrained to receive primary care services from their PCP and have specialty care prior authorized by the PCP.

4. ___ ***Other Statutes Waived*** - Please list any additional section(s) of the Act the State requests to waive, including an explanation of the request.

I. Enrollment Figures:

Please indicate the number of enrollees the State seeks to enroll in the waiver program by the end of the 2-year waiver program:

125,000+

J. ***Waiver Population:*** The waiver is limited to the following target groups of recipients. Check all items that apply:

1. _X_ **AFDC** - Aid to Families with Dependent Children and AFDC-related.

2. _X_ **SSI** - Supplemental Security Income and SSI-related.

3. _X_ **Other** - If checked, please describe these populations below:

A) State Supplemental Eligibles: Medicaid eligibles who are disabled or aged whose total income is less than their needs as compared to a state standard
B) Children eligible through Title XXI

K. ***Enrollment Requirement:*** Enrollment in the Program is:

1. _X_ Mandatory

2. _X_ Voluntary

3. ___ Other - If checked, please describe:

L. ***Excluded Populations:*** The following recipients will be excluded from participation in the waiver:

1. ___ have Medicare coverage, except for purposes of Medicaid-only services; e.g., dual eligibles;

2. ___ have other insurance;

3. _X_ are residing in a nursing facility or an Intermediate Care Facility for the Mentally Retarded (ICF/MR);

4. ___ are enrolled in another managed care program;

5. _X_ have an eligibility period that is less than 3 months;

6. _X_ have an eligibility period that is only retroactive;

7. ___ are eligible as medically needy;

8. ___ are eligible as foster care children;

9. ___ participate in a home and community-based waiver; or

10. _X_ have other reasons which may exempt beneficiaries from participating under the waiver program. Please explain those reasons below:

A) Are eligible as SLMB or QMB only
B) Must travel more than 30 miles or 30 minutes to obtain services
C) Live in a county that is not participating in the waiver program
D) Have an existing primary care relationship with a provider/clinic not participating in Healthy Connections
E) Have been placed on lock-in
F) Have incompatible third party liability

M. Access Standards

1. Distance/Travel Times: Please define the States access standards for distance and travel times for beneficiaries to receive services. Explain how distance and travel times will be monitored at the State and Plan levels.

If a Medicaid recipient has to travel more than 30 miles or 30 minutes to obtain services from the nearest Healthy Connections PCP, s/he can be exempted from mandatory participation in the program.

Monitoring of travel times and distances is conducted in two ways.

A) A question concerning travel is included in the annual client survey. The results of the 2001 survey follow:

How far do you travel to see your primary care physician?	
0-5 miles	56%
6-20 miles	31%
21-30 miles	10%
> 30 miles	3%

Participants traveling over 30 miles were asked an additional question concerning the reason with 29% indicating it was personal choice (of PCP) and 71% responding that the PCP was the closest provider. (Annual client survey results are included in their entirety as Appendix A)

B) As part of processing a program disenrollment or change of PCP, a reason for the change in enrollment is ascertained (by the HRC) during a brief exit interview with participants requesting such changes. The reason is coded into the system and results are compiled on a quarterly basis. In the last eight calendar quarters, twenty-two participants either changed PCP or were disenrolled from the program with the 30mile/30 minute reason code. A summary of the results follows:

Quarter Ending	3/31	6/30	9/30	12/31
2000		3	1	10
2001	5	1	0	1
2002	1			

A complete summary of changes in participation (by reason code) is included in Appendix B.

2. **Appointment Waiting Times**: Please define the States standards for appointment waiting times. Examples of access standards typically used by States are: in-office waiting times or the time before a beneficiary can acquire an appointment with his or her provider for both urgent and routine visits. Explain how waiting time standards will be monitored at the State and Plan levels.

Access standards for waiting times are <48 hour for immediate care and < 14 days for routine care. Monitoring of waiting times is conducted in two ways:

A) Questions regarding appointment waiting times are included in the annual client survey. (Annual client survey results are included in their entirety as Appendix A.) The 2001 results indicated the majority of enrollees are able to access their PCP in a reasonable time period for both immediate and routine care as follows.

Wait Time for Immediate Care		Wait Time for Routine Care	
0-24 hours	63%	0-7 days	60%
24-48 hours	28%	8-14 days	22%
>48 hours	9%	> 14 days	18%

B) As part of processing a program disenrollment or change of PCP, a reason for the change in enrollment is ascertained (by the HRC) during a brief exit interview with participants requesting such changes. The reason is coded into the system and results are compiled on a quarterly basis. A complete summary of changes in participation (by reason code) is included in Appendix B.

In the last eight calendar quarters, 125 participants have either changed their PCP or have been disenrolled from the program due to long wait times. However, only 34 of these individuals reported wait times longer the standard. A summary of the results follows:

Immediate Care- wait time > 48 hrs

Quarter Ending	3/31	6/30	9/30	12/31
2000		4	3	0
2001	0	0	1	5
2002	4			

Routine Care- wait time > 14 days

Quarter Ending	3/31	6/30	9/30	12/31
2000		1	1	3
2001	0	4	3	5
2002	0			

N. Independent Assessment:

The State will arrange for an Independent Assessment of the cost-effectiveness of the waiver and its impact on enrollee access to care of adequate quality. The Independent Assessment is required for at least the first two waiver periods. **This assessment is to be submitted to HCFA at least 3 months prior to the end of the waiver period**. [Please refer to SMM 2111 and HCFA's "Independent Assessment: Guidance to States" for more information]. Please check one of the following:

1.__ This is the first or second renewal of the waiver. An Independent Assessment has been completed and submitted to HCFA as required.

2. X Independent Assessments have been completed and submitted for the first two waiver periods. The State is requesting that it not be

required to arrange for additional Independent Assessments unless HCFA finds reasons to request additional evaluations as a result of this renewal request. In these instances, HCFA will notify the State that an Independent Assessment is needed in the waiver approval letter.

An assessment of the Healthy Connections program was conducted in 2000 by the Lewin Group at the direction of the Legislative Office of Performance Evaluations. This report is available on the internet at http://www2.state.id.us/ope/Reports/rept0005.pdf .

O. [Required] A copy of the PCCM contract to be used under the waiver is attached for HCFA review.

Included are copies of current provider agreements as well as draft copies of proposed provider agreements to be used under the waiver. Finalization of the new agreements will be conducted in conjunction with guidance provided by CMS in attaining compliancy with BBA requirements and are to be implemented in conjunction with finalization of BBA requirement

COORDINATED CARE PROVIDER AGREEMENT
(PROFESSIONAL CORPORATION)

This AGREEMENT is effective _____, 19_____, between The Idaho Department of Health and Welfare ("DEPARTMENT"),

and

_____, an Idaho professional corporation, whose shareholders are duly licensed or otherwise legally authorized within the state of Idaho to render one or more of the same professional services as the corporation ("PROVIDER").

1. PURPOSE OF AGREEMENT.

DEPARTMENT is Idaho's administering Medicaid agency with authority under Idaho Code, Title 56, Chapter 2, to enter into contracts for the provision of services to recipients of medical assistance ("PATIENTS/RECIPIENTS") and is authorized by federal law to provide such services in a coordinated care setting pursuant to a Health Care Financing Administration ("HCFA") waiver. PROVIDER desires to assist the DEPARTMENT by providing patient care and case management services to PATIENTS/RECIPIENTS. The purpose of this Agreement is to set forth the understanding of DEPARTMENT and PROVIDER to provide patient care and case management services for PATIENTS/RECIPIENTS for the purpose of increasing access to care and reducing costs by effective utilization.

2. OBLIGATIONS OF PROVIDER.

2.1 Health Care Management. PROVIDER shall be responsible for making all reasonable efforts to monitor and manage PATIENT/RECIPIENTS' care, provide primary care services, and make referrals when medically necessary for Covered Services provided by other than PROVIDER. Covered Services are defined as the services covered under the State Medicaid Plan as set forth in Title 3, Chapter 9, and Title 3, Chapter 10 of 16 IDAPA.

2.2 Abide by Rules and Regulations. PROVIDER agrees to be bound by the rules and regulations, and any subsequent amendments, set forth in Title 3, Chapter 9 (relating to medical assistance); Title 3, Chapter 10 (relating to provider reimbursement); Title 5, Chapter 1 (relating to confidentiality); Title 5, Chapter 2 (relating to provider audits); and Title 5, Chapter 3 (relating to contested cases) of 16 IDAPA ("Rules"), or such successor rules or amendments as DEPARTMENT shall promulgate from time to time.

2.3 Availability. PROVIDER agrees to make available 24-hour, 7 days per week access by telephone to a live voice (an employee of PROVIDER or an answering service) or an answering machine which will immediately page an on-call medical professional so that referrals can be made for non-emergency services or information can be given about accessing services or about medical problems during non-office hours.

2.4 Maintain Records. PROVIDER shall maintain a complete medical record for each PATIENT/RECIPIENT in accordance with the requirements set forth in the Rules. Medical records of PATIENTS/RECIPIENTS will include: (1) the record of services provided by the PROVIDER; (2) other records, if in PROVIDER'S possession, such as reports from referral providers, discharge summaries, or records of emergency care received by the PATIENT/RECIPIENT; and (3) such other information as DEPARTMENT requires. Medical records of PATIENTS/RECIPIENTS shall be treated as confidential so as to comply with all federal and state laws and regulations regarding the confidentiality of patient records.

2.5 Review and Service Programs. Provider shall cooperate and participate in such review and administrative procedures as may be established by DEPARTMENT, including utilization review and quality assurance programs, billing procedures, external audit systems, and PATIENT/RECIPIENT and PROVIDER grievance procedures.

2.6 Insurance. Unless otherwise agreed by DEPARTMENT, PROVIDER shall maintain at PROVIDER'S expense during the term of this Agreement professional liability insurance covering PROVIDER for malpractice claims made during and after termination of this Agreement based on conduct alleged to have occurred during the term of this Agreement with limits acceptable to DEPARTMENT. PROVIDER shall furnish to DEPARTMENT certificate(s) evidencing the existence of such insurance coverage on or before the effective date of this Agreement.

3. OBLIGATIONS OF DEPARTMENT.

3.1 Availability of Rules. The Rules (including any changes or amendments) shall be available to PROVIDER for inspection as provided in Idaho Code Section 67-5205, or its successor.

3.2 List of PATIENT/RECIPIENTS. DEPARTMENT shall provide to PROVIDER a list of PATIENTS/RECIPIENTS who have selected or have been assigned to PROVIDER, provided that the number of PATIENTS/RECIPIENTS shall not exceed the number of PATIENTS/RECIPIENTS that PROVIDER is permitted pursuant to the Rules.

4. COMPENSATION.

4.1 Payment for Services. PROVIDER shall be compensated for services rendered under this Agreement as follows:

Covered Services:	fee-for-service consistent with the Rules and federal regulations.
Case Management Services:	the greater of (a) $3.50 per PATIENT/RECIPIENT per month or (b) such payment as DEPARTMENT shall establish from time to time by written notice to PROVIDER.

4.2 No Recourse. Except as otherwise provided in the Rules, PROVIDER shall accept the payment set forth in this Section as payment in full for services. PROVIDER agrees that in no event including, but not limited to, non-payment, shall PROVIDER bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against PATIENT/RECIPIENT or persons other than DEPARTMENT acting on a PATIENT/RECIPIENT'S behalf for services provided pursuant

to this Agreement. This provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of PATIENT/RECIPIENT.

5. TERM;TERMINATION.

5.1 Term. This Agreement shall be for a term of one (1) year from the effective date and shall automatically renew each year unless terminated as provided in this Section.

5.2 Termination by DEPARTMENT. The DEPARTMENT may terminate this Agreement with or without cause as provided in the Rules, or in order to conform with federal or state law.

5.3 Termination by PROVIDER. The PROVIDER may terminate this Agreement with or without cause effective on the last day of any month by giving DEPARTMENT written notice at least sixty (60) days prior to the date of termination of PROVIDER'S intent to terminate this Agreement.

5.4 Effect of Termination. Upon termination, the rights of each party under the Agreement shall terminate; provided, however, that such action shall not release PROVIDER or DEPARTMENT from their obligations with respect to (a) payments accrued to PROVIDER prior to termination; (b) PROVIDER'S agreement not to seek compensation from PATIENTS/RECIPIENTS for services provided prior to termination; and (c) completion of treatment of PATIENTS/RECIPIENTS then receiving care until either (i) alternative care of PATIENTS/RECIPIENTS can be arranged or (ii) PROVIDER terminates the physician/patient relationship with PATIENT/RECIPIENT by giving PATIENT/RECIPIENT and DEPARTMENT at least thirty (30) days' written notice of termination of the physician/patient relationship, whichever occurs first. In the event of termination, DEPARTMENT is empowered and authorized to notify PATIENTS/RECIPIENTS, other providers, and other persons or entities of such termination.

6. AMENDMENT.

DEPARTMENT may amend this Agreement at any time without cause as provided in the Rules, or in order to conform with federal or state law.

7. INDEMNIFICATION.

7.1 Indemnification by PROVIDER. PROVIDER shall indemnify, defend and save harmless the State of Idaho, and DEPARTMENT, its officers, agents, and employees, from and against all liability, claims, damages, losses, expenses, actions, and suits whatsoever caused by or arising out of PROVIDER'S performance, act, or omission of any term of this Agreement. Nothing in this provision shall extend PROVIDER'S indemnification of DEPARTMENT beyond the liability of DEPARTMENT provided in the Idaho Tort Claims Act, Idaho Code ' 6-901, et seq.

7.2 Indemnification by DEPARTMENT. DEPARTMENT shall indemnify, defend and save harmless PROVIDER, its officers, agents, and employees, from and against all liability, claims, damages, losses, expenses, actions, and suits whatsoever caused by or arising out of DEPARTMENT'S performance, act, or omission of any term of the Agreement. Nothing in this provision shall extend the liability of DEPARTMENT beyond the liability of DEPARTMENT provided in the Idaho Tort Claims Act, Idaho Code ' 6-901, et seq.

8. RELATIONSHIPS OF PARTIES.

None of the provisions of this Agreement is intended to create nor shall be deemed or construed to create any relationship between the parties to this Agreement other than that of independent entities contracting with each other solely for the purposes of effecting the provisions of this Agreement. Neither of the parties to this Agreement, nor any of their respective employees, shall be construed to be the agent, employer, employee, or representative of the other, nor will either party have an express or implied right of authority to assume or create any obligation or responsibility on behalf of or in the name of the other party.

9. ASSIGNMENT.

This Agreement, being intended to secure the services of and be personal to PROVIDER, shall not be assigned, sublet, delegated, or transferred by PROVIDER without the prior written consent of DEPARTMENT which consent may be withheld by DEPARTMENT without cause.

10. NOTICE.

Any notice required to be given pursuant to the terms and provisions of this Agreement shall be sent by certified mail, return receipt requested, postage prepaid, to DEPARTMENT or to PROVIDER at the respective addresses given below. Notice shall be deemed to be effective when mailed, but notice of change of address shall be effective upon receipt.

DEPARTMENT
Idaho Department of Health and Welfare
Division of Medicaid
Healthy Connections
P. O. Box 83720
Boise, ID 83720-0036

By: _____
Pam Mason, R.N.
Program Manager

PROVIDER

_____

_____

_____

By: _____

_____
(Printed Name and Title) (Date)

Draft

COORDINATED CARE PROVIDER AGREEMENT
(PROFESSIONAL CORPORATION)

This AGREEMENT is effective _____, 20_____, between The Idaho Department of Health and Welfare ("DEPARTMENT"),

and

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_____, an Idaho professional corporation, whose shareholders are duly licensed or otherwise legally authorized within the state of Idaho to render one or more of the same professional services as the corporation ("PROVIDER").

1. PURPOSE OF AGREEMENT.

DEPARTMENT is Idaho's administering Medicaid agency with authority under Idaho Code, Title 56, Chapter 2, to enter into contracts for the provision of services to recipients of medical assistance ("PATIENTS/RECIPIENTS") and is authorized by federal law to provide such services in a coordinated care setting pursuant to a Health Care Financing Administration ("HCFA") waiver. PROVIDER desires to assist the DEPARTMENT by providing patient care and case management services to PATIENTS/RECIPIENTS. The purpose of this Agreement is to set forth the understanding of DEPARTMENT and PROVIDER to provide patient care and case management services for PATIENTS/RECIPIENTS for the purpose of increasing access to care and reducing costs by effective utilization.

2. OBLIGATIONS OF PROVIDER.

2.1 Health Care Management. PROVIDER shall be responsible for making all reasonable efforts to monitor and manage PATIENT/RECIPIENTS' care, provide primary care services, **allow enrollee choice of health professional to the extent possible and appropriate,** and make referrals when medically necessary for Covered Services provided by other than PROVIDER. Covered Services are defined as the services covered under the State Medicaid Plan as set forth in Title 3, Chapter 9, and Title 3, Chapter 10 of 16 IDAPA. **Provider shall have arrangements with, or referrals to sufficient numbers of physicians and other practitioners to ensure that services can be furnished to enrollees promptly and without compromise to quality of care. Provider shall restrict enrollment to PATIENTS/RECIPIENTS [THINK ABOUT USING ENROLLEES???] who reside sufficiently near to allow for reaching the site within a reasonable time using available and affordable modes of transportation.**

2.2 Abide by Rules and Regulations. PROVIDER agrees to be bound by **and comply with pertinent federal regulations at 42 CFR § 438, including § § 438.6(d) and (f) (relating to discrimination); § 442.128,) if appropriate (relating to advance directives); § 438.10, (relating to information requirements, including free translation or interpreter**

services, as appropriate);§§ 438.6 and 438.56 (relating to disenrollment); § 438.100

(relating to enrollee rights); and § 438.104 (relating to marketing activities); and § 438.700 (relating to sanctions). Provider agrees to be bound by and comply with the following rules: ~~and regulations~~, and any subsequent amendments**~~, set forth in~~ :** Title 3, Chapter 9 (relating to medical assistance); Title 3, Chapter 10 (relating to provider reimbursement); Title 5, Chapter 1 (relating to confidentiality); Title 5, Chapter 2 (relating to provider audits); and Title 5, Chapter 3 (relating to contested cases) of 16 IDAPA ("Rules"), or such successor rules or amendments as DEPARTMENT shall promulgate from time to time.

2.3 Availability. PROVIDER agrees to **have reasonable and adequate hours of operation. Provider agrees to** make available 24-hour, 7 days per week access by telephone to a live voice (an employee of PROVIDER or an answering service) or an answering machine which will immediately page an on-call medical professional so that referrals can be made for non-emergency services**, ~~or~~** information can be given about accessing services**,** or about **emergency** medical problems during non-office hours. **[could be just the language of the reg : Provider shall maintain reasonable and adequate hours of operation, including 24-hour availability of information, referral and treatment for emergency medical conditions.]**

2.4 Maintain Records. PROVIDER shall maintain a complete medical record for each PATIENT/RECIPIENT in accordance with the requirements set forth in the Rules. Medical records of PATIENTS/RECIPIENTS will include: (1) the record of services provided by the PROVIDER; (2) other records, if in PROVIDER'S possession, such as reports from referral providers, discharge summaries, or records of emergency care received by the PATIENT/RECIPIENT; and (3) such other information as DEPARTMENT requires. **[** Medical records of PATIENTS/RECIPIENTS shall be treated as confidential so as to comply with all federal and state laws**, ~~and~~** regulations **and rules** regarding the confidentiality of patient records. **] [this repeats what is above – need once]**

2.5 Review and Service Programs. Provider shall cooperate and participate in such review and administrative procedures as may be established by DEPARTMENT, including utilization review and quality assurance programs, billing procedures, external audit systems, and PATIENT/RECIPIENT and PROVIDER grievance procedures.

2.6 Insurance. Unless otherwise agreed by DEPARTMENT, PROVIDER shall maintain at PROVIDER'S expense during the term of this Agreement professional liability insurance covering PROVIDER for malpractice claims made during and after termination of this Agreement based on conduct alleged to have occurred during the term of this Agreement with limits acceptable to DEPARTMENT. PROVIDER shall furnish to DEPARTMENT certificate(s) evidencing the existence of such insurance coverage on or before the effective date of this Agreement.

2.7. Fairness. Provider shall not discriminate in enrollment, disenrollment, and reenrollment, based on the recipient's health status or need for health care services in compliance with 42 CFR § 438.6(k)(4) and § 438.10. Provider agrees to comply with all federal and state civil rights laws.

3. OBLIGATIONS OF DEPARTMENT.

3.1 Availability of Rules. The Rules (including any changes or amendments) shall be available to PROVIDER for inspection **~~as provided in Idaho Code Section 67-5205, or its successor~~ upon request. [could also give the home page cite]**

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Covered Services: fee-for-service consistent with the Rules and federal regulations.

Case Management Services: the greater of (a) $3.50 per PATIENT/RECIPIENT per month or (b) such payment as DEPARTMENT shall establish from time to time by written notice to PROVIDER.

4.2 No Recourse. Except as otherwise provided in the Rules, PROVIDER shall accept the payment set forth in this Section as payment in full for services. PROVIDER agrees that in no event including, but not limited to, non-payment, shall PROVIDER bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against PATIENT/RECIPIENT or persons other than DEPARTMENT acting on a PATIENT/RECIPIENT'S behalf for services provided pursuant to this Agreement. This provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of PATIENT/RECIPIENT.

5. TERM; TERMINATION.

5.1 Term. This Agreement shall be for a term of one (1) year from the effective date and shall automatically renew each year unless terminated as provided in this Section.

5.2 Termination by DEPARTMENT. The DEPARTMENT may terminate this Agreement with or without cause as provided in the Rules **[??]**, or in order to conform with federal or state law. **Notice of termination for cause shall be provided in writing, and shall include a**

statement of the reason for the Department's action and right of appeal and pretermination hearing.

5.3 Termination by PROVIDER. The PROVIDER may terminate this Agreement with or without cause effective on the last day of any month by giving DEPARTMENT written notice at least sixty (60) days prior to the date of termination of PROVIDER'S intent to terminate this Agreement.

5.4 Effect of Termination. Upon termination, the rights of each party under the Agreement shall terminate; provided, however, that such action shall not release PROVIDER or DEPARTMENT from their obligations with respect to (a) payments accrued to PROVIDER prior to termination; (b) PROVIDER'S agreement not to seek compensation from PATIENTS/RECIPIENTS for services provided prior to termination; and (c) completion of treatment of PATIENTS/RECIPIENTS then receiving care until either (i) alternative care of PATIENTS/RECIPIENTS can be arranged or (ii) PROVIDER terminates the physician/patient relationship with PATIENT/RECIPIENT by giving PATIENT/RECIPIENT and DEPARTMENT at least thirty (30) days' written notice of termination of the physician/patient relationship, whichever occurs first. In the event of termination, DEPARTMENT is empowered and authorized to notify PATIENTS/RECIPIENTS, other providers, and other persons or entities of such termination.

6. AMENDMENT.

DEPARTMENT may amend this Agreement at any time without cause as provided in the Rules, or in order to conform with federal or state law.

7. INDEMNIFICATION.

7.1 Indemnification by PROVIDER. PROVIDER shall indemnify, defend and save harmless the State of Idaho, and DEPARTMENT, its officers, agents, and employees, from and against all liability, claims, damages, losses, expenses, actions, and suits whatsoever caused by or arising out of PROVIDER'S performance, act, or omission of any term of this Agreement. Nothing in this provision shall extend PROVIDER'S indemnification of DEPARTMENT beyond the liability of DEPARTMENT provided in the Idaho Tort Claims Act, Idaho Code ?6-901, et seq.

7.2 Indemnification by DEPARTMENT. DEPARTMENT shall indemnify, defend and save harmless PROVIDER, its officers, agents, and employees, from and against all liability, claims, damages, losses, expenses, actions, and suits whatsoever caused by or arising out of DEPARTMENT'S performance, act, or omission of any term of the Agreement. Nothing in this

provision shall extend the liability of DEPARTMENT beyond the liability of DEPARTMENT provided in the Idaho Tort Claims Act, Idaho Code ?6-901, et seq.

8. RELATIONSHIPS OF PARTIES.

None of the provisions of this Agreement is intended to create nor shall be deemed or construed to create any relationship between the parties to this Agreement other than that of independent entities contracting with each other solely for the purposes of effecting the provisions of this Agreement. Neither of the parties to this Agreement, nor any of their respective employees, shall be construed to be the agent, employer, employee, or representative of the other, nor will either party have an express or implied right of authority to assume or create any obligation or responsibility on behalf of or in the name of the other party.

9. ASSIGNMENT.

This Agreement, being intended to secure the services of and be personal to PROVIDER, shall not be assigned, sublet, delegated, or transferred by PROVIDER without the prior written consent of DEPARTMENT which consent may be withheld by DEPARTMENT without cause.

10. NOTICE.

Any notice required to be given pursuant to the terms and provisions of this Agreement shall be sent by certified mail, return receipt requested, postage prepaid, to DEPARTMENT or to PROVIDER at the respective addresses given below. Notice shall be deemed to be effective when mailed, but notice of change of address shall be effective upon receipt.

DEPARTMENT
Idaho Department of Health and Welfare
Division of Medicaid
Healthy Connections
P. O. Box 83720
Boise, ID 83720-0036

By: _____

PROVIDER

_____

By: _____

Pam Mason, R.N.
Program Manager

_____

(Printed Name and Title)

(Date)

III. PROGRAM IMPACT:

In the following informational sections, please complete the required information to describe your program.

a. **Marketing** including indirect PCCM and PCCM administrator marketing (e.g., radio and TV advertising for the PCCM and/or PCCM administrator in general) and direct PCCM and PCCM administrator marketing (e.g. direct mail to Medicaid beneficiaries). For information to enrollees (i.e., member handbooks), see Section H.

Previous Waiver Period

1.__ During the last waiver period, the program marketing policies operated differently than described in the waiver governing that period. Please explain why the program operated differently and what the differences were:

2._ [Required for all elements checked in the previous waiver submittal] Please describe how often and through what means the State monitored compliance with its marketing requirements [items A.III.a.1-7 of 1999 initial application; as applicable in 1996 submittal], as well as results of the monitoring.

N/A- marketing requirements are new to this waiver

Upcoming Waiver Period Please describe the waiver program for the upcoming two-year period. For items 1. through 8. of this section, please identify any responses that reflect a change in program from the previous waiver submittal by placing two asterisks (i.e., "**") after your response.

1.___ The State does not permit direct or indirect primary care case manager marketing (go to item “b. Enrollment/Disenrollment”)

2.___ The State permits indirect primary care case manager marketing (e.g., radio and TV advertising for the primary care case manager in general). Please list types of indirect marketing permitted.

3._X_ The State permits direct primary care case manager marketing (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

PCPs are prohibited from marketing to Medicaid clients, with the exception of contacting established patients (as identified by the Department) to request enrollment using materials developed by the Department.

Please describe the State's procedures regarding direct and indirect marketing by answering the following questions, if applicable.

4._X_ The State prohibits or limits primary care case managers from offering gifts or other incentives to potential enrollees. Please explain any limitation/prohibition and how the State monitors this:

Neither PCCMs nor the State shall engage in practices that provide incentives, other than the incentive of a medical home, to participants. All activities conducted as enrollment initiatives follow established oversight procedures and will be piloted and analyzed prior to implementing at a statewide level.

This will be monitored by the HRCs as established in complaints received from clients or other parties and any violations reported to the Program Manager and/or designated oversight committee. Additionally, at least one question will be added to the 2002 client survey to address inappropriate marketing practices.

5.___ The State permits primary care case managers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited for the primary care case manager. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

6._X_ The State requires primary care case manager marketing materials to be translated into the languages listed below (If the State does not translate or require the translation of enrollee materials, please explain): Spanish, when applicable

The State has chosen these languages because (check any that apply):

i._ _ The languages comprise all prevalent languages in the primary care case manager service area. Please describe the methodology for determining prevalent languages.

ii._X The languages comprise all languages in the primary care case manager service area spoken by approximately 5 percent or more of the population.

iii.__ Other (please explain):

7.___ The State imposes intermediate sanctions against a primary care case manager if the State determines that the primary care case manager distributed false or misleading marketing material. Please describe.

8. **Required Marketing Elements**: Listed below is a description of requirements which the State must meet under the waiver program (items 1.a through 1.g). If an item is not checked, please explain why. The State:

(a) X_ Ensures that all marketing materials are prior approved by the State

(b) X_ Ensures that primary care case manager marketing materials do not contain false or misleading information

(c) __ Consults with the Medical Care Advisory Committee (or subcommittee) in the review of primary care case manager marketing materials (Marketing in this manner is limited to use of standardized State program materials.)

(d) __ Ensures that the primary care case manager distributes marketing materials to its entire service area (Type of marketing permitted does not allow this)

(e)_X Ensures that the primary care case manager does not offer the sale of any other type of insurance product as an enticement to enrollment.

(f)_X_ Ensures that the primary care case manager does not conduct directly or indirectly, door-to-door, telephonic, or other forms of "cold-call" marketing.

(g) X Ensures that primary care case manager does not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of health services.

b. Enrollment/Disenrollment:

Previous Waiver Period

1.__ During the last waiver period, the enrollment and disenrollment operated differently than described in the waiver governing that period. Please explain why the program operated differently and what the differences were:

2. [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State has monitored compliance with Enrollment/Disenrollment requirements [items A.III.b of the 1999 initial application; items III.A.1 of 1996 submittal]. Please include the results from those monitoring efforts for the previous waiver period.

Upcoming Waiver Period - Please describe the State's enrollment process by checking the applicable items below. For items 1. through 6. of this section, please identify any responses that reflect a change in program from the previous waiver submittal by placing two asterisks (i.e., "**") after your response.

1. Will the **State administer** the enrollment process or is an **independent contractor** (i.e., enrollment broker) be responsible for this process? If the State plans to utilize an independent contractor, please specify. Also include the name and specific role of the contractor, i.e., is it for purposes of enrollment only, or is the contract for other services as well.

State administered enrollment process.

2. Beneficiary enrollment:

a. At what site and how will most of the beneficiaries initially be enrolled into the program? Please describe the State's enrollment system.

Applicants receive initial HC information with their notification of eligibility determination. Beneficiaries can return a completed enrollment form from this mailing. In voluntary counties, most beneficiaries sign an enrollment form at their primary care doctor's office.

Voluntary Enrollment County

When the Medicaid client completes the enrollment form, the client will identify the physician or clinic each eligible family member sees for general health care. When the HRC receives an incomplete or unclear enrollment form, the employee contacts the head of household to verify the information on the form. If necessary, the HRC verifies that the identified physician/clinic is a HC provider and is able to accept the new client(s) into his/her practice. If a client in a voluntary county completes an enrollment form asking for assistance to find a primary care physician (PCP), the employee will work with the client to select a PCP.

When all information is verified, the HRC enters the enrollment information into the Advanced Information Management System (AIMS) which automatically generates a confirmation letter to the client. This letter advises the client of the effective enrollment date; confirms the client's physician/clinic name, address, and telephone number.

Mandatory Enrollment County

All Medicaid clients residing in a mandatory county are required to join Healthy Connections unless they meet one of the exemptions listed in Section II.L. Non-responsive clients are assigned to PCPs during a monthly enrollment process conducted by the HRCs.

b. How will beneficiaries be choice counseled in the selection of their PCPs?

Should an individual need help in selecting a PCP, they can contact their local Healthy Connections Representative to receive information and advice on the types, availability and location of PCPs in their area.

c. How long will beneficiaries have in order to choose a PCP?

Voluntary counties: N/A
Mandatory counties: 60 days after initial contact with enrollment effective the 1st of the next month after assignment.

d. How will beneficiaries notify the State of their provider choice?

1. By filling out an enrollment form at their doctor's office
2. By contacting Healthy Connections in writing

3. By contacting a Healthy Connections Representative via telephone

3. If a beneficiary does not select a PCP within the given time frame, will the beneficiary be **autoassigned or default assigned** to a PCP?

____ no X yes but only in mandatory counties **If yes, please describe the autoassignment process and/or algorithm

Prior to converting a county from voluntary to mandatory status, a Memorandum of Participation (MOP) is signed by each participating PCP in which the rotational default assignment process agreed to by the PCPs is delineated.

In counties with only Family Practice PCPs, rotational assignment is fairly straight forward. A list of individuals who are not enrolled is generated on a monthly basis. If one family member is already enrolled, remaining family members will be placed with the same PCP. Remaining individuals are rotationally assigned in family units to each PCP as identified in the MOP.

In counties with either Pediatricians, Internists, and/or OB/GYNs PCPs, the rotational assignment is further refined to place individuals with appropriate types of PCPs (i.e. children with pediatricians or family practice).

An example of a Memorandum of Participation (MOP) follows:

MEMORANDUM OF PARTICIPATION
OPERATIONAL PROCEDURES FOR
MANDATORY HEALTHY CONNECTIONS

Effective Date: April 1, 2002

This agreement is between the Division of Medicaid and the primary care providers in **Madison** County.

PURPOSE: The purpose of this agreement is to clarify and outline the mandatory participation procedures of the Department of Health and Welfare's Division of Medicaid and the primary care providers hereafter referred to as HC PCP's, in the implementation of Madison County as a mandatory Healthy Connections Program area. Healthy Connections hereafter referred to as HC.

PARTIES: Department of Health and Welfare Division of Medicaid and Madison County Primary Care Provider(s):

THE DIVISION OF MEDICAID SHALL:

1. Provide sufficient information to determine that adequate Primary Care Provider (PCP) access exists within Madison
   County to implement mandatory Healthy Connections participation under Idaho Medicaid.
2. Work with the HC PCP's to establish the necessary rotation to enroll Medicaid eligible recipients who do not choose a HC PCP. (The HC PCP can either be a Madison County PCP or any other PCP within the Region.)
3. Work with the HC PCPs to establish a protocol to address how referrals will be handled by the assigned HC PCP if the recipient has not been seen by the assigned HC PCP, but referral for existing services is needed, i.e. physical therapy.
4. Mail out notification of Mandatory status to the Medicaid recipients within the county, asking them to identify their present PCP or be assigned a provider within the county/counties in 90 days. **Recipients already enrolled will not be asked to reenroll.**
5. Provide follow-up and support for providers i.e. staff training and community training.
6. Oversee all client enrollments.
7. Serve as the liaison to PCPs for HC issues.

THE PARTICIPATING PRIMARY CARE PROVIDERS SHALL:

1. Agree to accept on a rotational basis those Medicaid recipients in the county eligible for Healthy Connections – those currently eligible and those who become eligible in the future.
2. Allow the HC program to use the PCP names, addresses, phone numbers and information on HC information sent out to the county Medicaid eligible recipients.
3. Exempt from enrollment any Medicaid recipient who qualifies for one of the exemptions below:
   a. Recipient does not live in program area, or,
   b. lives 30 miles or 30 minutes from HC provider and there is a non-HC Provider closer or
   c. resides in a Nursing facility or Intermediate Care Facility for the Mentally Retarded (ICF/MF), or,
   d. is eligible as a Qualified Medicare Beneficiary(QMB) only, or
   e. has a pre-existing relationship with a non-participating or out of area provider for primary care.
   f. has been placed on Medicaid lock-in.
4. Not disenroll any HC participant without cause and consultation with the Regional Health Resources Coordinator.
5. Comply with the HC Program protocols for referrals when a client has been discharged from the practice.
6. Work with the Division of Medicaid to establish a protocol to address how referrals will be handled by assigned HC PCPs if the recipient has not been seen by the assigned HC PCP, but referral for existing services is needed i.e. physical therapy.
7. **ROTATION AGREEMENT:**

Based on individual and group conversations with Madison County Primary Care Provider(s)/Practices, the following is the agreed upon rotation schedule for enrollment of new Medicaid recipients into the providers practice. This rotation schedule is only for those recipients who do not make a voluntary choice and do not fall into any of the exemption categories.

1. **Rexburg Medical Center** will participate in the rotational assignment of all "units". They will take one "unit" per provider in their practice on each rotation.

2. **Rexburg Family Care**, will participate in the rotational assignment of all "units". They will take one "unit" per provider in their practice on each rotation.

3. **Rexburg Family Medical Center** will participate in the rotational assignment of all "units". They will take one "unit" per provider in their practice on each rotation.

4. **Targhee Medical Specialist** (Dr. C. Rammell) will not participate in the rotation.

5. **Dr. Gates** will participate in the rotational assignment of "units" that consist of children only. He will take one "unit" per rotation.

6. **Targhee Medical Specialists** (Dr. Lofgren) will participate in the rotational assignment of "units" that consist of children only. He will take one "unit" per rotation.

7. **Targhee Medical Specialists** (Dr. Lovell) will participate in the rotational assignment of "units" that consist of a pregnant woman only. They will take one "unit" per rotation.

8. **Madison Women's Clinic** will participate in the rotational assignment of "units" that consist of a pregnant woman only. They will take one "unit" per rotation.

*A unit can be an individual or a family composed of more than one member

SIGNATORS OF AGREEMENT:

For the Division of Medicaid: **Madison County Primary Care Provider**:

_____ _____

Regional Health Resource Coordinator **Name**

Date: _____ **Date: _____**

_____

Bureau of Medicaid Benefits and Reimbursement Policy
Customer Service Manager

Date: _____

_____

Medicaid Services Program Manager

Date:_____

4. Will there be **accommodations** for the enrollment (if applicable) of special needs populations such as the disabled, persons living with HIV/AIDS, children, etc?

(For example, please explain if a woman in her third trimester of pregnancy became eligible for the program, would she be able to remain in her current physician?s care until the birth of the child, even if the physician was not a PCP under the waiver program? Also, for example, are disabled beneficiaries who utilize a specialist most frequently for their care permitted to have a specialist for a PCP? If no, please explain.)

A goal of Healthy Connections is to strengthen the patient/physician relationship. It is not the intent of the program to sever a Medicaid participant's relationship with a physician (or other provider able to act as a PCP) providing primary care services.

A) Beneficiaries who have an existing relationship with a non-participating PCP can request an exemption from mandatory program participation

B) Specialists serving as PCPs to special needs populations can choose to participate as a PCP in Healthy Connections

5. ***Enrollment Materials:*** Please include all relevant beneficiary enrollment materials, including the **initial notification letter** from the State. Also check the items which will be provided to the beneficiaries:

a. _X_ a **brochure** explaining the program

b. _X_ an **form** for enrollment in the waiver program and selection of a PCP

c. _X_ a **list of qualified PCPs** serving the recipient's geographical area (in mandatory counties only);

d. ___ A ***new*** **Medicaid card** which includes the PCP's name and telephone number or a ***sticker*** noting the physician's name and telephone number to be attached to the original Medicaid card (please specify which method);

e. ___ Every new enrollee will be given **a brief presentation and informing materials** describing how to appropriately access

services under the managed care system, including the appropriate usage of emergency rooms and family planning services under the waiver program, and how to exercise due process rights; and

f. _X_ other items (please explain below):

See Appendix E for examples of all enrollment materials.

6. List the **languages** into which the program educational materials will be translated into.

Spanish

Will these comprise all languages in the program area spoken by approximately 10 percent or more of the population? If no, please explain.

Yes

7. Will there be any provisions to provide **interpretative** services for hearing-impaired beneficiaries and beneficiaries whose primary language is spoken by less than 10 percent of the population?

Yes. Standards are that bilingual (Spanish-speaking) staff are available within the program and all staff dealing directly with the public are trained in the use of AT&T Language line and the Idaho Relay Service (hearing impaired phone system) to assist limited English speaking individuals.

c. Entity Type or Specific Waiver Requirements:

Previous Waiver Period

1.___ During the last waiver period, the program operated differently than described in the waiver governing that period. Please explain why the program operated differently and what the differences were:

Upcoming Waiver Period -- Please describe the entity type or specific waiver requirements for the upcoming two-year period. For items 1. through 4. of this section, please identify any responses that reflect a change in program from the previous waiver submittal by placing two asterisks (i.e., "**") after your response.

1. **[Required] Types of Qualifying primary care case managers:** Following is a list of the types of providers that qualify to be Primary Care Providers under the waiver (Please also fill out section B.III.d):

(a) X Physicians

i._X_ Pediatricians

ii. X Family Practitioners

iii. X Internists

iv. X General Practitioners

v. X Obstetrician/Gynecologists

(b) X FQHCs

(c) X RHCs

(d) X Certified Nurse Practitioners
*If this provider is not included as a PCCM type, how will these services be made available (please describe):

(e) X Nurse midwives
*If this provider is not included as a PCCM type, how will these services be made available (please describe):

(f) X Indian Health Service clinics or providers

(g) X Physician Assistants

(h) X Other (Please describe):

Specialists (i.e. oncologists, etc.) who agree to provide primary care services and 24 hour access to clients with special health care needs.

2. **Primary Care Provider Requirements:** Below is a description of primary care case manager qualifications and requirements under the waiver. If the State program differs in any of the following aspects, whether to include additional requirements or exclude some of the requirements, please note below and explain each difference. Primary care case managers must:

(a)X be Medicaid qualified providers and agree to comply with all

applicable federal statutory and regulatory requirements, including those in Section 1932 of the Act and 42 CFR 434 (and the new 42 CFR 438 once effective); all State plan standards regarding access to care and quality of service;

(b)X sign a contract or addendum for enrollment as a primary care case manager which explains the primary care case managers responsibilities and which complies with the PCCM contract requirements in Section 1905(t)(3) of the Act including: make available 24-hour, 7 days per week access by telephone to a live voice (an employee of the primary care case manager or an answering service) or an answering machine which will immediately page an on-call medical professional for information, referral, and treatment of medical emergencies; referrals for non-emergency services; or to information about accessing services or how to handle medical problems during non-office hours;

(c)X provide comprehensive primary health care services to all eligible Medicaid beneficiaries who choose or are assigned to the primary care case manager's practice;

(d)X refer or have arrangements for sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;

(e)X have hours of operations that are reasonable and adequate; (Please define for your State):

PCCM office hours of operation are subject to community standards on an individual basis but are expected to conform to a minimum standard of 40 hours per week to be considered as a PCCM for Healthy Connections. As part of entering into agreement with a PCP for case management services under the waiver, the potential PCCM declares its hours of operation to the State. Considerations for participation as a HC PCCM with hours of operation less than 40 hours per week must be accompanied with a statement for arrangement of services to appropriate providers in lieu of office hours (must be cost neutral to the program and provide reasonable access to participants). To date, such arrangements have been limited to rural and frontier counties to accommodate local service delivery systems. Currently there are no provider agreements in effect that accommodate hours of operation of less than 40 hours per week with the exception of a limited number (<5) in rural areas where the PCP office is a satellite clinic of a larger, geographically appropriate and accessible PCP.

(f)_X_not refuse an assignment or disenroll an enrollee or otherwise discriminate against an enrollee solely on the basis of age, sex, race, physical or mental handicap, national origin, or health status or need for health services, except when that illness or condition can be better treated by another provider type;

(g)X take beneficiaries in the order in which they enroll with the primary care case manager;

(h)X not have an affiliation with person debarred, suspended, or otherwise excluded from federal procurement activities per Section 1932(d)(1) of the Act;

(i)_X_ restrict enrollment to individuals residing sufficiently near a service delivery site of the primary care case manager to be able to reach that site within a reasonable time using available and affordable modes of transportation;

(j)___ other qualifications (please explain):

4. **Required Elements Relating to Waiver under Section 1915(b)(4):** If the State is requesting a waiver under Section 1915(b)(4) of the Social Security Act, please mark the items that the State is in compliance with:

Idaho is not requesting a waiver under Section 1915(b)(4)

4. **Reimbursement of Providers:** Under this waiver, providers are reimbursed on a fee-for-service basis. Primary Care Case Managers are reimbursed for patient management in the following manner (please check and describe). This answer should be consistent with your response in Section D.I.

(a)_X_ A fee of **$ 3.50** per member per month is paid to the case manager;

(b)___Enhanced fee for primary care services;

(c)___Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization; and

(d)__ Other reimbursement/amount $____ (please explain).

5. **Referrals:** Please explain in detail the process for a patient referral. In the State's description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.

Primary care providers make referrals by:

- Filling out a referral form and either sending it with the patient or sending it (FAX, mail) to the receiving provider
- Same as above, but using a prescription pad
- Phoning the referral to the receiving provider. In this case, the details of the referral are written into the patients records on both sides

All referrals are to be documented in the permanent patient records of both providers. Providers receiving referrals are to report outcomes back to the primary care provider.

d. Services

Previous Waiver Period

1.__ During the last waiver period, the program operated differently than described in the waiver governing that period. Please explain why the program operated differently and what the differences were:

2._X_ [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State has monitored compliance with service provision requirements. [items A.III.d.2-6 of the 1999 initial application; items III.B.1 and IV.D of the 1996 submittal]. Please include the results from those monitoring efforts for the previous waiver period.

The 2001 annual client survey included a question regarding access to specialty care. Fifty-one percent (51%) of respondents indicated that they had obtained specialty care through referral processes since enrollment in the program. Of those respondents indicating that they had obtained a referral to specialist services, an additional question was asked regarding who initiated the referral request. Seventy-nine percent (79%) of those referred to specialty services indicated that their PCP had initiated the referral to specialty treatment. Seventeen percent (17%) indicated that they had initiated the referral request. Seven percent (7%) indicated that they utilized alternative routes of access to initialize specialty services. Annual client survey results are included in their entirety as Appendix A

Upcoming Waiver Period -- Please describe the service-related requirements for the upcoming two year period. For items 1. through 6. of this section, please identify any responses that reflect a change in program from the previous waiver submittal by placing two asterisks (i.e., "**") after your response.

1. X The Medicaid services that primary care case managers will be responsible for delivering, prescribing, or making referrals to are listed in the chart below. The purpose of the chart is to show which of the services in the State's State plan do/do not require prior authorization/referral; which non-covered services are impacted by the PCCM program (i.e. for calculating cost effectiveness; see Appendix D.III); and which new services are available only through the PCCM program under a 1915(b)(3) waiver. When filling out the chart, please do the following:

(Column 1 Explanation) Services: The list of services below is provided as an example only. States should modify the list to include:

-- all services available in the State's State Plan, regardless of whether they will be included or excluded under the waiver
-- subset(s) of State plan amendment services which will be carved out, if applicable; for example, list mental health separately if it will be carved out of physician and hospital services
-- services not covered by the State plan (note: only add these to the list if this is a 1915(b)(3) waiver, which uses cost savings to provide additional services)

(Column 2 Explanation) State Plan Approved: Check this column if this is a service included under the waiver and it is a Medicaid State Plan approved service. This information is needed because only Medicaid State Plan approved services can be included in cost effectiveness. For 1915(b)(3) waivers it will also distinguish existing Medicaid versus new services available under the waiver. Please note: services under the waiver that do not require prior authorization or referral should be marked as well as services that require prior authorization or referral.

(Column 3 Explanation) 1915(b)(3) waiver services: If a covered waiver service is not a Medicaid State Plan approved service, check this column. Marking this column will distinguish new services available under the waiver versus existing Medicaid service.

(Column 4 Explanation) Referral/Prior Authorization Required: Check this column if this service will be included in the waiver and will require a referral/prior authorization. All services checked in this column should be marked in Appendix D.III in the Services Requiring Referral column.

(Column 5 Explanation) Referral/Prior Authorization Not Required or Non-Waiver Services: Check this column if this service will not be included in the waiver. Do not include services impacted by the PCCM (see column 6).

(Column 6 Explanation) Wraparound Service impacted by PCCM: Check this column if the service is not covered under the waiver and does not require a referral/prior authorization, but is impacted by it. For example, a goal of most primary care case management programs is that emergency services would be reduced. For example, if the State pays for pharmacy on a FFS basis, but does not require a referral from the primary care case manager to process those claims, the primary care case manager will still impact pharmacy use because access to drugs requires a physician prescription. All services checked in this column should appear in Appendix D.III Wraparound Services column. Do not include services NOT impacted by the waiver.

Service (1)	State Plan Approved (2)	1915(b)(3) Waiver Services (3)	Referral/ Prior Auth. Required (4)	Referral/ Prior Auth... Not Required or Non-Waiver Services (5)	Wraparound Service Impacted by PCCM (6)
Day Treatment Services	X		X		
Dental	X		Some services require PA	X	
Detoxification	X		X		
Developmental Disabilities Services (please explain)	X		X		
Durable Medical Equipment	X		X		
Education Agency Services	X		X		
Emergency Services	X			X	
EPSDT	X		X		
Family Planning Services	X			X	
Federally Qualified Health Center Services	X		X		
Home Health	X		X		
Hospice	X		X		
Inpatient Hospital -	X		X		

Service (1)	State Plan Approved (2)	1915(b)(3) Waiver Services (3)	Referral/ Prior Auth. Required (4)	Referral/ Prior Auth... Not Required or Non-Waiver Services (5)	Wraparound Service Impacted by PCCM (6)
Psych					
Inpatient Hospital - Other	X		X		
Immunizations	X			X	
Lab and x-ray	X		X		
Mental Health Services (Please specify) All	X		X		
Nurse midwife	X		X		
Nurse practitioner	X		X		
Nursing Facility	X		X		
Obstetrical services	X		X		
Occupational therapy	X		X		
Other fee-for-service services					
Other Outpatient Services -- Please Specify					
Other Psych Practitioner					
Outpatient Hospital - All	X		X		

Service (1)	State Plan Approved (2)	1915(b)(3) Waiver Services (3)	Referral/ Prior Auth. Required (4)	Referral/ Prior Auth... Not Required or Non-Waiver Services (5)	Wraparound Service Impacted by PCCM (6)
Other	X		X		
Outpatient Hospital - Lab & X-ray	X		X		
Partial Hospitalization					
Personal Care	X			X	
Pharmacy	X		PA required for some drug classes		X
Physical Therapy	X		X		
Physician	X		X		
Private duty nursing	X		X		
Prof. & Clinic and other Lab and X-ray	X		X		
Psychologist					
Rehabilitation Treatment Services	X		X		
Respiratory care	X		X		
Rural Health Clinic	X		X		
Speech Therapy	X		X		
Substance Abuse	X		X		

Service (1)	State Plan Approved (2)	1915(b)(3) Waiver Services (3)	Referral/ Prior Auth. Required (4)	Referral/ Prior Auth... Not Required or Non-Waiver Services (5)	Wraparound Service Impacted by PCCM (6)
Treatment Services					
Testing for sexually transmitted diseases (STDs)	X			X	
Transportation - Emergency	X			X	
Transportation - Non-emergency	X			X	
Vision Exams and Glasses	X			X	
Other -- Please specify					
Other Pharmacy Services -- Please specify (e.g., Health Drugs)					
Other Mental Health Services- Please Specify					
Other Inpatient Services - Please Specify					

2. X **[Required] Emergency Services**. The State must ensure enrollees have access to emergency services without prior authorization. Under PCCM programs , "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

(a)__ The State has a more stringent definition of emergency medical condition than the definition above. Please describe.

The State takes the following required steps to ensure access to emergency services. If an item below is not checked, please explain.

(b)_X The State ensures enrollee access to emergency services by providing adequate information to all enrollees regarding emergency service access (see Section H. Enrollee Information and Rights)

(c)_X The State ensures enrollee access to emergency services by reimbursing for the following.

All services rendered in a hospital Emergency Department.

3. X **Family Planning**: In accordance with 42 CFR 431.51(b), preauthorization by the enrollee's primary care case manager for family planning services is prohibited under the waiver program. Please describe how enrollees are informed that family planning services will not be restricted under the waiver.

4._X_ **Other Services to Which Enrollee Can Self-Refer**: In addition to emergency care and family planning, the State requires PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) to the following services (Please note whether self-referral is allowed only to network providers or to non-network providers):

List of services not requiring PCP referral:

- Childhood Immunizations
- Chiropractic Care
- Dental Care performed in the office*
- Emergency Care performed in an Emergency Department (including emergency transportation)
- Family Planning Services
- Hearing Tests/Screening performed by an audiologist
- Indian Health Clinic services
- Personal Care Services (PCS) and PCS case management
- Pharmacy Services (prescription drugs)
- Podiatry Services performed in the office*
- Screening Mammography (1 per calendar year for women 40+)
- Sexually Transmitted Disease testing
- Vision Services performed in the office*, includes glasses

  * surgical procedures in either an inpatient or outpatient (ASC) setting require a referral

5.___ **Monitoring Self-Referral Services**: The State places the following requirements on the PCCM to track, coordinate, and monitor services to which an enrollee can self-refer:

6. X **Federally Qualified Health Center:** (FQHC) Services will be made available to enrollees under the waiver in the following manner (indicate one of the following, and if the State's methodology differs, please explain in detail below):

(a)_X The program is **voluntary in some counties.** If the client lives in a voluntary county served by an FQHC, the enrollee can disenroll at any time if he or she desires access to FQHC services. No FQHC services will be required to be furnished to the enrollee during the enrollment period.

(b)_X The program is **mandatory in some counties.** If the client lives in a mandatory county served by an FQHC, the enrollee will have the right to choose an FQHC as a primary care case manager, or choose a primary care case manager that contracts with an FQHC. If the beneficiary elects not to select the primary care case manager that would give him or her access to FQHC services, no FQHC services are required to be furnished to the beneficiary while the beneficiary is enrolled with the primary care case manager he or she selected. Since reasonable access to FQHC services is available under the waiver program, FQHC

services outside the program are not available.

c)__ The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

7. **EPSDT Services:** The State will coordinate and monitor EPSDT services under the waiver program as follows:

(a) _X The State collects EPSDT data from primary care case managers (claims, etc). Please describe the type and frequency of data collected by the State.

Information is captured by the MMIS as claims are submitted and submitted in the required HCFA416 format.

(b)_X EPSDT screens are covered under this waiver. Please list the State's EPSDT screening rates, including behavioral components, for the past two years, for the Medicaid population as a whole. (Please note*: HCFA requests that each State obtain a baseline of EPSDT and immunization data in the initial application. That baseline may be the data reported in the HCFA 416 report or it may be rates/measures more specific to the Medicaid managed care population. Those rates will be monitored in future renewals.) Please describe any activities the State will undertake to improve the percentage of screens administered for enrollees under the waiver.

Age	**2000**	**2001**
<1	54%	49%
1-2	42%	62%
3-5	24%	28%
6-9	23%	24%
10-14	21%	23%
15-18	17%	20%
19-20	4%	4%

A client education component is currently under development and will be implemented this year. Information will include the importance of well-child checks. Additionally, PCPs will be reminded at least annually of the importance of billing the wellness visit codes (when appropriate).**

(c) __ Immunizations are included in this waiver. Please list the State's immunization rates for the past two years for the Medicaid population as a whole. *See note in (b) above. What activities will the State initiate to improve immunization rates for enrollees within the waiver?

Although immunizations are not included under this waiver, the program is committed to working with immunization initiatives to improve immunization rates to the Idaho population as a whole. For the first three series of shots, Idaho's rate of immunizations is in the low 90s. By the time children are ready to go to school the rate is approximately 95%. Rates reflect a decline in the percentage for the 2 year old age group.

(d)__ Primary Care Case Managers are required to enroll in the Vaccines for Children Program. If not, please explain.

Although most, if not all, PCPs are enrolled in the Vaccines for Children Program, it is not required for participation in the PCCM program and this is not currently monitored. Childhood immunizations do not require a referral and may be obtained at the District Health Departments, all of which are enrolled in the Vaccines for Children Program.

(e) X_ Mechanisms are in place to coordinate school services with those provided by the primary care case manager. Please describe and clarify the aspects of school services that are coordinated including IEPS, IFSPs, special education requirements, and school-based or school-linked health centers (e.g., requirements for primary care case manager cooperation or involvement in the development of the IEPs).

School-based services, including the IEP require a referral from the PCP. When a school identifies a child in need of services and begins plan development, the school contacts the PCP to request a referral for the IEP and any needed services identified in the IEP.

(f)_X Mechanisms are in place to coordinate other aspects of EPSDT (e.g., dental, mental, Title V, etc) with those provided under the PCCM program. Please describe.

Initiatives are underway to improve communications between stakeholders across the spectrum of the Healthy Connections program. This includes targeted training and educational efforts to providers of EPSDT and related services. Specifically being implemented is an internet site to improve standardized program information and communication methods to all stakeholders.

Section B. Access and Capacity

A 1915(b)(1) waiver program serves to improve a beneficiary's access to quality medical services. A waiver must assure an adequate amount of services during reasonable time periods and within reasonable geographic distance from the residences of the individuals enrolled under the waiver. Furthermore, access to emergency and family planning services must not be restricted.

I. Access Standards

Previous Waiver Period

a.___ During the last waiver period, the access standards of the program were operated differently than described in the waiver governing that period. Please explain why the program operated differently and what the differences were:

Upcoming Waiver Period -- For items a. through c. of this section, please identify any responses that reflect a change in program from the previous waiver submittal by placing two asterisks (i.e., "**") after your response. Please describe the State's availability standards for the upcoming waiver period.

a. **Availability Standards:** The State has established maximum distance and travel time requirements, given clients' normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard and answer monitoring questions 3, 4, 5 for the upcoming waiver period:

1. _X_ PCCMs (please describe your standard):

   30 miles or 30 minutes one way

2. ___ Other providers (please describe your standard):

3. _X_ Please explains how often and how the State monitors compliance and what incentives/sanctions/enforcement the State makes with each of the standards described above.

   If a Medicaid recipient has to travel more than 30 miles or 30 minutes to obtain services from the nearest Healthy Connections PCP, s/he can be exempted from mandatory participation in the program.

   Monitoring of travel times and distances is conducted in two ways.

   a) A question concerning travel is included in the annual client survey. The results of the 2001 survey follow:

How far do you travel to see your primary care physician?	
0-5 miles	56%
6-20 miles	31%
21-30 miles	10%
> 30 miles	3%

Participants traveling over 30 miles were asked an additional question concerning the reason with 29% indicating it was personal choice (of PCP) and 71% responding that the PCP was the closest provider. Annual client survey results are included in their entirety as Appendix A

b) As part of processing a program disenrollment or change of PCP, a reason for the change in enrollment is ascertained (by the HRC) during a brief exit interview with participants requesting such changes. The reason is coded into the system and results are compiled on a quarterly basis. In the last eight calendar quarters, twenty-two participants either changed PCP or were disenrolled from the program with the 30mile/30 minute reason code. A summary of the results follows:

Quarter Ending	3/31	6/30	9/30	12/31
2000		3	1	10
2001	5	1	0	1
2002	1			

A complete summary of changes in participation (by reason code) is included in Appendix B.

4. _X_ Please explain how the distance and travel time to obtain services under the waiver will not be further or longer than prior to the waiver.

a) Clients living more than 30 miles or 30 minutes from the nearest participating PCP can be exempted from participation

b) In mandatory counties, clients without an established PCP relationship are assigned to a local PCP.

c) Counties will not be converted to mandatory status unless the PCPs in the county agree to provide adequate access to participants

d) Disenrollment is not restricted under the waiver and participants can change to a closer PCP

5. _X_ Please explain how the State will ensure enrollees have access to providers.

The State will continue assessments and monitoring of access issues. As the liaison between providers and participants, HRCs provide a mechanism for early intervention of situations that may lead to diminished access. When a participant contacts an HRC with a complaint, the HRC contacts the PCPs office to ascertain the validity of the complaint and offer assistance in resolving the issue, if necessary. Additionally, HRCs visit each PCP office a minimum of once each calendar quarter to provide technical assistance and other requested training.

b. **Appointment Scheduling** (Appointment scheduling means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits.) The State has established standards for appointment scheduling for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard and answer monitoring questions 3 and 4 for the upcoming waiver period.

1. _X_ PCCMs (please describe your standard):

Access standards for waiting times are <48 hour for immediate care and < 14 days for routine care.

2. ___ Other providers (please describe your standard):

3. _X_ Please explain how often and how the State monitors compliance and what incentives/sanctions/enforcement the State makes with each of the appointment scheduling standards checked above.

Monitoring of waiting times is conducted in two ways:

A) Questions regarding appointment waiting times are included in the annual client survey (see Appendix A). The 2001 results indicated the majority of enrollees are able to access their PCP in a reasonable time period for both immediate and routine care as follows:

Wait Time for Immediate Care		Wait Time for Routine Care	
0-24 hours	63%	0-7 days	60%
24-48 hours	28%	8-14 days	22%
>48 hours	9%	> 14 days	18%

B) As part of processing a program disenrollment or change of PCP, a reason for the change in enrollment is ascertained (by the HRC) during a brief exit interview with participants requesting such changes. The reason is coded into the system and results are compiled on a quarterly basis. In the last eight calendar quarters, 125 participants have either changed their PCP or have been disenrolled from the program due to long wait times. However, only 34 of these individuals reported wait times longer the standard. A summary of the results follows:

Immediate Care- wait time > 48 hrs

Quarter Ending	3/31	6/30	9/30	12/31
2000		4	3	0
2001	0	0	1	5
2002	4			

Routine Care- wait time > 14 days

Quarter Ending	3/31	6/30	9/30	12/31
2000		1	1	3
2001	0	4	3	5
2002	0			

A complete summary of changes in participation (by reason code) is included in Appendix B.

4. _X_ Please explain how often and how the State assures that appointment scheduling time frames are not longer than the non-waiver appointment scheduling.

The State will continue assessments and monitoring of access issues. As the liaison between providers and participants, HRCs provide a mechanism for early intervention of situations that may lead to diminished access. When a participant contacts an HRC with a complaint, the HRC contacts the PCPs office to ascertain the validity of the complaint and offer assistance in resolving the issue, if necessary. Additionally, HRCs

visit each PCP office a minimum of once each calendar quarter to provide technical assistance and other requested training.

c. In-Office Waiting Times: The State has established standards for in-office waiting times for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard and answer monitoring questions 3 and 4 for the upcoming waiver period.

1. ___ PCCMs (please describe your standard):

2. __ Other providers (please describe your standard):

3. ___Please explain how often and how the State monitors compliance and what incentives/sanctions/enforcement the State makes with each of the in-office waiting time standards checked above.

4. ___Please explain how the State assures that in-office waiting times are not longer than the non-waiver in-office waiting times.

II. Access and Availability Monitoring

Previous Waiver Period

a._X_ During the last waiver period, the access and availability monitoring was operated differently than described in the waiver governing that period. Please explain why the program operated differently and what the differences were:

After-hours monitoring of PCPs was not conducted on a quarterly basis. The PCPs were monitored once in 2000 and twice in 2001. This reduction in monitoring was due to staffing issues and that historically very few PCPs (<10%) were found out of compliance.

Results of the 2000 monitoring indicated that 8 of 212 PCP offices (13.7%) called were out of compliance and required follow-up to bring into compliance. However, the results of the (first) monitoring in 2001 indicated that 68 of 204 PCP offices (33%) had fallen out of compliance. Since this represented a large increase, another round of monitoring was conducted in 2001. Results of this monitoring indicated the 21 of 171 PCP offices (12.2%) called were out of compliance and required follow-up to bring back into compliance.

Based on the results of the monitoring in the last two years, it has been determined that monitoring of PCPs after-hours availability needs to be monitored at least semi-annually.

Additionally, a question was added to the 2001 client survey to address this change. Twenty-nine percent of respondents indicated that they had attempted to contact their PCP after hours and of these, 7% indicated that they had been unable to reach someone. This question will be asked again in the 2002 survey.

b. _X_ [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring access and availability in the previous two year period. [item B.II in the 1999 initial application; item IV.C in the 1996 submittal].

Upcoming Waiver Period -- For items a. through r. of this section, please identify any responses that reflect a change in program from the previous waiver submittal by placing two asterisks (i.e., "**") after your response. Check below any of the following (a-q) that the State will also utilize to monitor access for the upcoming waiver period:

a. _X_ Measurement of access to services during and after a primary care case manager's regular office hours to assure 24 hour accessibility, 7 days a week (e.g., primary care case managers' 24-hour accessibility will be monitored through random calls to primary care case managers during regular and after office hours)

b. ___ Ensures that services are provided in a culturally competent manner to all enrollees.

c. ___ Review of access to emergency or family planning services without prior authorization

d. _X_ Review of denials of referral requests

e. _X_ Review of the number and/or frequency of visits to emergency rooms, non-authorized visits to specialists, etc., for medical care.

Review of participant emergency room usage will be a new component to the waiver program.**

f. _X_ Tracking of enrollee requests for disenrollment from a primary care case manager due to access issues

g. _X_ Tracking of complaints/grievances concerning access issues

h. _X_ Monitoring access to prescriptions on the State Plan Formulary, Durable Medical Equipment, and therapies.

i. _X_ Monitoring long waiting periods to obtain services from a primary care

case manager.

j. ___ Monitoring the provision and payment for transportation for beneficiaries to get to their outpatient, medically necessary mental health services.

k. ___ Monitoring the disparities affecting ethnic and racial minorities in accessing care (e.g., access to emergency rooms, return visits to providers, referral denial rates).

l. _X_ Other (please explain): Monitoring of non-emergency transportation for medically necessary services

III. Capacity Standards

Previous Waiver Period

a. ___ During the last waiver period, the capacity standards were operated differently than described in the waiver governing that period. Please explain why the program operated differently and what the differences were:

b.___ [Required if elements III.a.1 and III.a.2 were marked in the previous waiver submittal] The State has monitored to ensure that enrollment limits and open panels were adequate and that provider capacity remained approximately the same or improved under the waiver. Please describe the results of this monitoring by describing how standards were monitored and identified issues addressed.

c._X_ [Required] Capacity Standards. The State ensured that the number of providers under the waiver remained approximately the same or increased compared to the number before the implementation of the waiver. Please describe the results of this monitoring.

Upcoming Waiver Period -- Please identify any responses that reflect a change in program from the previous waiver submittal by placing two asterisks (i.e., "**") after your response. Please describe the capacity standards for the upcoming two-year period.

1. ___ The State has set enrollment limits for the primary care case managers. Please describe a) the enrollment limits and how each is determined and b) a description of how often and through what means the limits are monitored and changed.

2. ___ The State monitors to ensure that there are an adequate number of

primary care case managers accepting new patients (i.e. having open panels) within the PCCM program. Please describe how often and how the monitoring takes place.

3. _X_ [Required] The State ensures that the number of providers under the waiver is expected to remain approximately the same or increase compared to the number before the implementation of the waiver. Please describe how the State will ensure that provider capacity will remain approximately the same or improve under the waiver.

4. _X_ [Required] For all provider types in the program, list in the chart below for each geographic area(s) applicable to your State, the number of providers before the waiver, during the current waiver period and the number projected for the proposed renewal period. **Please provide a definition of your geographic area,** i.e. by county, region or rate area. Please complete only for the providers included in your waiver program.

This is the first time that CMS has requested information on Provider # Before the Waiver to be accounted for at a less than statewide level. This information is not available and therefore this section is completed as in previous waiver renewals. The geographic area represented by this data is the State of Idaho.

Please modify to reflect your State's program and complete the following chart:

Providers	# Before the Waiver	# In Current Waiver	# Expected in Renewal
1. Pediatricians	66	91	100
2. Family Practitioners	140	358	500
3. Internists	180	82	90
4. General Practitioners	*575	27	27
5. OB/GYN, and GYN	77	47	50
6. FQHCs	11 (includes RHCs& IHS)	7	8
7. RHCs		11	12
8. Nurse Practitioners	50 (includes PAs)	99	110
9. Nurse Midwives	0	4	5

Providers	# Before the Waiver	# In Current Waiver	# Expected in Renewal
10. Indian Health Service Clinics		3	3
Additional Types of Provider to be PCCMs			
1.Physician Assistants		92	105
2.Other specialties		26	30
3.			
4.			

*Please note any limitations to the data in the chart above here: The number of General Practitioners participating before the Waiver seems unusually high based on current figures. We feel this is due to the difficulty in determining some physician specialties at that time.

5. ___ For those PCCMs that have multiple contracts with plans, please describe any efforts the State is making to monitor unduplicated Medicaid enrollment capacity across plans?

6. ___The State ensures adequate geographic distribution of PCCMs. Please explain.

7. _X_ ***Primary Care Physician Patient Ratio:*** Please calculate and list below the expected average PCCM/beneficiary ratio for each area or county of the program, and then provide a statewide average. The State must note any changes that will occur due to the use of physician extenders (e.g., physician assistants).

Area(City/County/Region)	*PCCM-to-Beneficiary Ratio*
Region I	1: <150
Region II	1: <100
Region III	1: <200
Region IV	1: <250
Region V	1: <200
Region VI	1: <250

Region VII	1: <250
Statewide Average: (e.g. 1:500 and 1:1,000)	1: <200

IV. Capacity Monitoring

Previous Waiver Period

a. ___ During the last waiver period, the capacity monitoring was operated differently than described in the waiver governing that period. Please explain why the program operated differently and what the differences were:

b. _X_ [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring capacity in the previous two year period [item B.IV in the 1999 initial application; items IV.C in the 1996 submittal].

Historically capacity standards for 1915(b) waiver programs has been a required element. This is the first (Idaho) waiver renewal since the BBA eliminated the requirement to establish a 75/25 threshold limitation, which in our last waiver renewal was 1253 participants per PCP. The highest PCP to enrollee ratio to date has been 1:775.

Upcoming Waiver Period -- For items a. through j. of this section, please identify any responses that reflect a change in program from the previous waiver submittal by placing two asterisks (i.e., "**") after your response.
Please indicate which of the following activities the State will employ for the upcoming waiver period:

a. _X_ Periodic comparison of the number and types of Medicaid providers before and after the waiver

b. _X_ Provider-to-enrollee ratios

c. _X_ Measurement of enrollee requests for disenrollment from a PCCM due to capacity issues

d. _X_ Tracking of complaints/grievances concerning capacity issues

e. ___ Geographic Mapping (please explain)

f. _X_ Tracking of termination rates of PCCMs

g. _X_ Review of reasons for PCCM termination

h. _X Consumer Experience Survey, including persons with special needs,

i. _X The State has criteria and/or procedures to assess adequate capacity relative to the demographics (e.g. age, sex, residence) of the targeted population in each geographic area (e.g. county ~~or region~~) prior to ~~implementing the waiver in that area~~. converting a county to mandatory status.

j. ___ Other (Please explain):

V. Continuity and Coordination of Care Standards

Previous Waiver Period

a.___ During the last waiver period, the continuity and coordination of care standards were operated differently than described in the waiver governing that period. Please explain why the program operated differently and what the differences were:

Upcoming Waiver Period -- For items a. through h. of this section, please identify any responses that reflect a change in program from the previous waiver submittal by placing two asterisks (i.e., "**") after your response. Check any of the following that the State will require of the PCCM provider for the upcoming waiver period:

a._X_ Each enrollee selects or is assigned to a primary care provider appropriate to the enrollee's needs

b._X_ Each enrollee selects or is assigned to a designated health care practitioner (**PCP)** who is primarily responsible for coordinating the enrollee's overall health care.

c.___ Health education/promotion. Please explain.

d._X_ Each provider maintains, for Medicaid enrollees, health records that meet the requirements established by the State, taking into account professional standards.

e._X_ There is appropriate and confidential exchange of information among providers.

f. _ _ Enrollees are informed of specific health conditions that require follow-up and, if appropriate, are given training in self-care

g. ___ Addresses factors that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.

h._X_ Case management (please define your case management programs).

1) EPSDT service coordination
2) PCS case management
3) Case management for the Mentally Ill
4) DD service coordination

VI. Continuity and Coordination of Care Monitoring

Previous Waiver Period

a.___ During the last waiver period, the continuity and coordination of care monitoring was operated differently than described in the waiver governing that period. Please explain why the program operated differently and what the differences were:

b.___ [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring continuity and coordination of care in the previous two year period [item B.VI in the 1999 initial application; Section IV.3 (as applicable) in 1996 submittal].

c.___ [Required for all elements checked in the previous waiver submittal] Please describe any continuity or coordination of care requirements with these entities that the State required during the previous waiver period for the entities marked in B.VI in the previous waiver submission (i.e., information sharing requirements or any efforts that the State has required to avoid duplication of services).

d.___ [Required for States with a PHP mental health, substance abuse, or developmentally disabled population waiver] Please describe the State's efforts during the previous waiver period to ensure coordination between FFS, PCCM, or MCO providers and PHP providers.

Upcoming Waiver Period -- For items a. and b. of this section, please identify any responses that reflect a change in program from the previous waiver submittal by placing two asterisks (i.e., "**") after your response. Please describe how standards for continuity and coordination of care will be monitored in the upcoming two year period.

a. How often and through what means does the State monitor the coordination standards checked above?

b. Specify below any providers that the State explicitly requires the PCCM to coordinate health care services with:

1. _X Mental Health Providers (please describe how the State ensures coordination exists):

   PCP referral required for services

2. _X Substance Abuse Providers (please describe how the State ensures coordination exists):.

   PCP referral required for services

3. __ Local Health Departments (please describe how the State ensures coordination exists):

4. __ Dental Providers (please describe how the State ensures coordination exists):

5. __ Transportation Providers (please describe how the State ensures coordination exists):

6. _X HCBS (1915c) Service (please describe how the State ensures coordination exists):

   PCP referral required for services (DD waiver)

7. _X Developmental Disabilities (please describe how the State ensures coordination exists):

   PCP referral required for services

8. __ Title V Providers (please describe how the State ensures coordination exists):

9. __ Women, Infants and Children (WIC) program

10. _X_ Indian Health Services providers

11. __ FQHCs and RHCs not included in the program's networks

12. __ Other (please describe):

Section C. Quality of Care and Services

A Section 1915(b) waiver program may not substantially impair enrollee access to medically necessary services of adequate quality. In addition, 1915(b) waiver programs must meet certain statutory or regulatory requirements addressing quality of health care. This section of the waiver submittal will document how the State met these requirements.

A Primary Care Case Management program (PCCM) serves to improve a beneficiary's access to quality medical services. The program must assure an adequate amount of services during reasonable time periods and within reasonable geographic distance from the residences of the beneficiaries enrolled in the waiver program. Furthermore, access to emergency and family planning services must not be restricted. Please note: we are defining quality as the degree to which health services for individuals and populations increases the likelihood of desired health outcomes and are consistent with current professional knowledge (Institute of Medicine, 1990).

I. Monitoring Quality of Services: This section provides the State the opportunity to explain in detail how the State will monitor access to and quality of services under the waiver program.

Previous Waiver Period -- This section provides the State the opportunity to describe the results of monitoring efforts that have been implemented to ensure the provision of quality health care services.

a.___ During the last waiver period, the program operated differently than described in the waiver governing that period. Please explain why the program operated differently and what the differences were:

b. [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts, including a description of any problems that were suspected or identified regarding quality of services, the intervention used by the State to address the problems, and the results of those interventions. Please also include a description of how results of any interventions by the State have been used for continuous quality improvement of the waiver program. If the State developed a Quality Improvement Strategy (QIS) for its PCCM program, please describe how it helped identify issues.

c. [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts, including summary results for any measures of PCCM or PCCM administrator performance, focused clinical projects, or performance improvement projects conducted in either clinical or non-clinical areas defined by the State during the previous waiver period. Please include a description of

how results of these evaluations/projects have been used for continuous quality improvement of the waiver program.

Upcoming Waiver Period -- Please respond to items a through e and complete any of the items below that the State requires. For items a through d please identify any responses that reflect a change in program from the previous waiver submittal by placing two asterisks (i.e., "**") after your response. Please describe those differences. The State:

a. Monitoring Methods. Please check any of the items that the State uses to monitor quality of services provided to enrollees in the PCCM program. For any items checked, please provide a description of the methods used:

1.___ Beneficiaries' reasons for changing primary care case managers (not only actual changes, but also requests to change specific primary care case managers);

2._X_ Beneficiary Hotline;

3._X_ Periodic enrollee experience surveys (which include questions concerning the enrollees access to and quality of services under the waiver) will be mailed to a sample of enrollees including persons with special needs. Corrective actions taken on deficiencies found are also planned;

4._X_ Provider Profiling;
- i.___ Periodic comparison of numbers and types of PCCMs before and after the waiver.
- ii.___ PCCM to enrollee ratios.
- iii._X_ Outliers in service utilization**
- iv.___ Other (please describe).

5._X_ Provider Surveys;

6.___ Performance Measures.

Please indicate what types of performance measures the State calculates to monitor its PCCM program:

- i.___ Process and Outcome Quality Measures
- ii.___ Access/Availability Measures
- iii._ _ Use of Services/Utilization Measures
- iv._ _ Cost of Care Measures
- v.___ Primary Care Case Manager Characteristic Measures

vi.___ Beneficiary Characteristic Measures
vii._X Other Performance Measures (please specify) ;

Feedback to PCPs on utilization of certain services for targeted disease management. The program for Pediatric Asthma is currently under development. Additionally, feedback mechanisms to PCPs on participant ER utilization is being developed at this time.**

7._ _ Focused studies. Focused studies are detailed investigations of certain aspects of clinical or non-clinical health care services at a point in time. The studies are designed to answer defined questions about the quality and appropriateness of care and to, if necessary, recommend how care can be improved. A focused study may be conducted by reviewing medical records, by reviewing claims or other administrative data, by conducting special surveys, or other mechanisms. These projects differ from performance improvement projects in that demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services is not required.

Please list the names of the focused study projects currently planned for the waiver period either at a State /PCCM program level or primary care case manager level. Please identify the clinical and/or non-clinical areas that are assessed in the study.

8._X_ Utilization Review

9.___ The State has developed a Quality Improvement Strategy (QIS) for its PCCM program. Please submit a copy of the State's QIS and/or quality improvement guidelines as an attachment to this section (Attachment C.I.a)

10.__ Other (please explain).

c. Quality Improvement: This section provides the State the opportunity to: 1) describe any minimum performance levels that have been established for health care quality performance measures that are calculated; and, 2) to describe information on any performance improvement projects implemented by the State. Please check the items below that the State, either itself or through the PCCM administrator, has implemented. The State:

1.___ Establishes minimum performance levels for quality performance measures calculated. Please list or attach the quality measures currently calculated for which minimum performance

levels are established.

2._X_ **Conducts performance improvement projects** that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care or non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction.

Please list the performance improvement projects currently planned for the waiver period either at a State/PCCM program level or at a primary care case manager level. Please identify the clinical (e.g., acute/chronic conditions, high-volume/high-risk services) and non-clinical (e.g., complaints, appeals, cultural competence, accessibility) focus areas assessed in the project(s).

- Pediatric Asthma clinical indicators**
- ER utilization **

c. Monitoring Personnel: The State conducts quality monitoring activities using (check all that apply):

1._X_ State Medicaid agency personnel including SURS personnel.

2.___ Other State government personnel (please specify).

3.___ A non-State agency contractor including fiscal agent, PCCM administrator staff, or other monitoring contractor (please specify).

4.___ Other (Please specify).

d. State Intervention: If a problem is identified regarding access to care or the quality of services received, the State will intervene as indicated below. Please check which methods will be used by the State to address any suspected or identified problems.

1._X_ Provide education and informal mailings to beneficiaries and primary care case managers;

2._X_ Initiate telephone and/or mail inquiries and follow-up;

3._X_ Request primary care case manager's response to identified problems;

4._X_ Refer to program staff for further investigation;

5._X_ Send warning letters to primary care case managers;

6._X_ Refer to State's medical staff for investigation;

7._X_ Institute corrective action plans and follow-up;

8._X_ Change a beneficiary's primary care case manager;

9.___ Institute a restriction on the types of beneficiaries;

10.__ Further limit the number of assignments;

11._X_Ban new assignments;

12._X_Transfer some or all assignments to different primary care case managers;

13._X_Suspend or terminate primary care case managers;

14._X_Suspend or terminate as Medicaid providers; and

15.___Other (explain):

II. Selection and Retention of Providers: This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a primary care case manager.

Previous Waiver Period

a.___ During the last waiver period, the selection and retention of providers were different than described in the waiver governing that period. Please explain why the program operated differently and what the differences were:

b. [Required for all elements checked in the previous waiver submittal] If a State contracts with a PCCM Administrator, please provide results from the State's monitoring efforts, including a description of any methods through which the State has monitored for problems related to the selection and retention of providers. Please explain how any problems

that have been suspected or identified during the previous waiver period have been addressed and/or resolved.

Upcoming Waiver Period -- Please check any processes or procedures listed below that the State uses in the process of selecting and retaining primary care case managers. Also please identify any responses that reflect a change in program from the previous waiver submittal by placing two asterisks (i.e., "**") after your response. Please describe those differences. The State (please check all that apply):

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining primary care case managers. The State (please check all that apply):

a.__ Has a documented process for selection and retention of primary care case managers (please submit a copy of that documentation).

b. __ Has an initial credentialing process for primary care case managers that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

c.__ Has a recredentialing process for primary care case managers that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):

1.__ Initial credentialing

2.__ Performance measures, including those obtained through the following (check all that apply):

(a)__ The utilization management system.

(b)__ The complaint and appeals system.

(c)__ Enrollee surveys.

(d)__ Other (Please describe).

d.__ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.

e.__ Has an initial and recredentialing process for primary care case managers

other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

f.__ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of primary care case managers take place because of quality deficiencies.

g._X Other (please describe).

PCCMs must be active Medicaid providers in good standing in order to participate in the waiver. Credentialing requirements are addressed as part of the process for initializing and maintaining Medicaid provider status.

III. Health Information Systems.

Previous Waiver Period

a.___ During the last waiver period, the health information systems operated differently than described in the waiver governing that period. Please explain why the program operated differently and what the differences were:

b. [Required for all elements checked in the previous waiver submittal] If a State contracts with a PCCM Administrator, please provide results from the State's monitoring efforts, including a description of any methods through which the State has monitored for problems related to the maintenance of its health information system. Please explain how any problems that have been suspected or identified during the previous waiver period have been addressed and/or resolved.

Upcoming Waiver Period -- Please check any of the processes and procedures from the following list that the State has in place to maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of the Medicaid Program. Also please identify any responses that reflect a change in program from the previous waiver submittal by placing two asterisks (i.e., "**") after your response. Please describe those differences. The State's systems:

a._X_ Collection of service utilization/claims data.

b.___ Collection of enrollee and provider characteristics data.

c._X_ System Capabilities. The State MMIS systems are capable of and routinely perform the following activities (please check all that apply):

1._X_ [Required] Recording sufficient patient data to identify the primary care case manager or other provider who delivered services to Medicaid enrollees.

2._X_ [Required] Verifying whether services reimbursed by Medicaid were actually furnished to enrollees.

3._X_ Verifying the accuracy and timeliness of data.

4._X_ Screening data for completeness, logic and consistency.

5._X_ Collecting service information in standardized formats to the extent feasible and appropriate.

6.___ Other (Please describe).

d._X_ Ensure that each primary care case manager furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the State or PCCM administrator that take into account professional standards.

e. ___ Other (please describe).

Section D. Cost Effectiveness

All Cost Effectiveness calculations are included in Appendix D (Excel workbook spreadsheets)

In order to meet cost effectiveness, a waiver renewal request must demonstrate that the cost of the waiver program during the initial two-year waiver period (Years 1 and 2) was less than the estimated costs of the program without the waiver. The renewal request must also exhibit cost-effectiveness in the upcoming two-year waiver period (Years 3 and 4).

HCFA offers the following suggestions to States in completing this section:

- States are strongly encouraged to use the revised waiver renewal submittal format to reduce the number of questions regarding their cost-effectiveness calculations. Please note that use of the revised waiver submittal is optional.
- Cost effectiveness for 1915(b) waivers is measured in total computable dollars (Federal and State share).
- States are not to be held accountable for caseload changes when submitting their waiver renewal cost-effectiveness calculations for services. States should have Per Member Per Month (PMPM) costs for the 2-year period equal to or less than projected Without Waiver costs as calculated in Step 18 of Appendix D.IV of their initial application. **Please ensure that you are using the PMPM Without Waiver costs that were approved in the previous waiver in your renewal.**
- Waiver expenditures should be reported on the Quarterly Medicaid Statement of Expenditures (Form HCFA-64 Report), according to reporting instructions in the State Medicaid Manual, Section 2500. If the State has specific questions regarding this requirement, please contact your State's HCFA accountant in the Regional Office.
- A set of sample Appendices has been included with this submittal using Year 2 of one State's experience (DSAMPLE.XLS). Blank Appendices have been included for your use (APPD.XLS). **Please modify the spreadsheets to meet your State's cost effectiveness methodology.** Please submit the electronic spreadsheets used to create the Appendices to HCFA (HCFA currently uses Excel, which will convert both Lotus and QuatroPro). Please structure the worksheets as schedules which can link the totals between spreadsheets and roll up into a summary if the State has that capability. Linking the sheets and summaries will reduce copying from one schedule to another, which may introduce errors.
- The costs and enrollment numbers for voluntary populations (i.e., populations that can choose between joining the PCCM program and staying in FFS) should be excluded from the waiver cost-effectiveness calculations if these individuals are not included in the waiver. In general, HCFA believes that voluntary populations should not be included in 1915(b) waivers (i.e., excluded in Section A.II.l and A.II.m). If the State wants to include voluntary populations in the waiver (i.e., listed in Section A.III.b.3), then the costs and enrollment numbers for the population must be included in the cost-effectiveness calculations. In addition, States that elect to include voluntary populations in the waiver are required to submit a written explanation of how selection bias will be addressed in the with waiver calculations. (Section V.D. With Waiver Development). HCFA may require the State to adjust its Without Waiver costs to account for selection bias.

Description of the Cost-Effectiveness Calculation Process:

Documentation for the Without Waiver costs must be calculated on a PMPM basis.

- In order to demonstrate cost-effectiveness for the initial waiver period (Year 1 and Year 2), States must first document the actual number of member months that participated in the program. They must then estimate the number of member months for the target population that will participate in the waiver program for the upcoming waiver period (Year 3 and Year 4). The member months estimation should be based on the actual State eligibility data in the base year and the experience of the program in Year 1 and Year 2. (Appendix D.II, Steps 1-4)
- The base year and the source of the without waiver data need to be identified for Years 1 - 4. The sources for this data and any adjustments to this data must be listed. If the State is proposing to use a different methodology for Years 3 and 4, the State will need to document all differences between the methodologies within this submittal. Without Waiver Costs should be created using FFS data with FFS utilization and FFS inflation assumptions. HCFA recommends that a State use at least three years of FFS Medicaid historical data to develop utilization and inflation trend rates. (Appendix D.III, Steps 5-9)
- Without waiver cost data and eligibility data for the population to be covered must be established. Base years should be specific to the eligibility group and locality covered by the waiver program. These base year costs need to be broken down into each of the main service categories covered under the contract–inpatient hospital, outpatient hospital, physician, lab and x-ray, pharmacy, and other costs. Base year costs should be calculated on a PMPM basis. (Appendix D. IV, Steps 10-13)

- Once the base year costs are established, States need to make adjustments to the data in order to update it to the years to be covered by the waiver program. These adjustments represent the impact on Medicaid costs from such things as inflation, utilization factors, administrative expenses, and program changes (Appendix D. IV, Steps 14-18). The State then needs to consider the effect of costs that are affected by the PCCM but not subject to PCCM referral. These services are generally referred to as wraparound services, and may include such services as pharmacy. Because the PCCM can affect the costs of these wraparound services, they must be included in the without waiver cost development. Without waiver costs must be developed for Years 1 - 4. The without waiver costs for Years 1 and 2 should reflect the same costs that were used for the initial waiver renewal. (Appendix D.IV, Steps 17-18).

- States must document actual PMPM costs under the waiver for the previous two-year period. They also must estimate the PMPM costs under the upcoming waiver period. The costs should include services controlled by the waiver but not requiring a PCCM referral, plus the agency's average per capita administrative costs related to these services (Appendix D.V, Steps 19-29).

- States must then calculate the aggregate costs without the waiver and the aggregate costs with the waiver (Appendices D.VI, D.VII, D.VIII, DIX, Steps 30-35).

- States must clearly demonstrate that, when compared, payments to the contractors plus administration costs did not exceed the Without Waiver Cost in the past two years and will not exceed the Without Waiver Cost in the future two years (Appendix D.VIII, Steps 36-40).

Assurance (Please initial or check)

__X_ The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.

Name of Medicaid Financial Officer: __Randy May, Deputy Administrator_____

Telephone Number: ___(208) 364-1804_____

The following questions are to be completed in conjunction with the Worksheet Appendices. We have incorporated step-by-step instructions directly into the worksheet using instruction boxes. Where further clarification was needed, we have included additional information in the submittal. All narrative explanations should be included in the submittal.

I. Reimbursement of Providers

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe). Responses must match those provided in Section A.II.c.6:

a._ X_ Management fees are expected to be paid under this waiver. The management fees were calculated as follows.

1._X_ First Year: $ 3.50 __ per member per month fee

2._X_ Second Year: $ 3.50 __ per member per month fee

3._X_ Third Year: $ 3.50 __ per member per month fee

4._X_ Fourth Year: $ 3.50 _ per member per month fee

b.___ Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

c.___ Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Please describe the criteria the State will use for awarding the incentive payments, the methodology for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the without waiver costs (Section D.V). Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in **Appendix D.V**. With Waiver costs.

d.___ Other reimbursement methodology/amount. $_____ Please explain the State's rationale for determining this methodology or amount.

II. Member Months: Appendix D.II

Purpose: To provide data on actual and projected enrollment during the waiver period. Actual enrollment data for the previous waiver period must be obtained from the State's tracking system. Projected enrollment data for the upcoming period is needed to determine whether the waiver is likely to be cost effective. This data is also useful in assessing future enrollment changes in the waiver.

Step 1: Please list the eligibility categories and rate cells for the population to be enrolled in the waiver program. The number and distribution of rate cells will vary by State. If the State used different cells in Years 1 & 2 than in Years 3 & 4, please create separate tables for the two waiver periods. The base year should be the same as the FFS data used to create the PMPM without waiver costs. Base year eligibility adjustments such as shifts in eligibility resulting in an increase or decrease in the number of member months enrolled in the program should be noted here. Note: because of the timing of the waiver renewal submittal, the State may need to estimate up to six (6) months of enrollment data for Year 2 of the previous waiver period.

Step 2: See instruction box. If the State estimates that all eligible individuals will not be enrolled in managed care (i.e., a percentage of individuals will be unenrolled because of eligibility changes and the length of the enrollment process) please note the adjustment here:

Step 3: See instruction box. In the space provided below, please explain any variance in member months, by region, from Year 1 to Year 4.

Step 4: See instruction box. In the space provided below, please explain any variance in total member months from Year 1 to Year 4.

a. Population in base year data

1._X_ Base year data is from the same population as to be included in the waiver.

2. __ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from the State

Financial Officer or other explanation to support the conclusion that the populations are comparable.)

III. Without Waiver Data Sources and Adjustments: Appendix D.III

Purpose: To explain the data sources and reimbursement methodology for base year costs.

To identify adjustments which must be made to base year costs in order to arrive at the without waiver costs for all waiver services.

To identify adjustments that will affect the With Waiver Costs.

NOTE: The data on this schedule will be used in preparing **Appendix D.IV Without Waiver Cost Development**. In order to develop the without waiver costs, States must use fee-for-service costs for the target population or a comparable population. At this time, HCFA cannot accept the use of encounter data or managed care experience to develop without waiver costs. Please note that encounter data or managed care experience may be used to develop with waiver costs.

NOTE: If the State is proposing to use a different methodology for Years 3 and 4 than were used in Years 1 and 2, please document all differences between the methodologies.

Step 5: Actual cost and eligibility data are required for base year PMPM computations. Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period. **Please note the waiver years that this methodology was in place. Submit separate Appendix D.III charts if different methodologies or services were used in the Without Waiver costs for the upcoming waiver period than in the previous waiver period.** Please provide an explanation in the space below if: a) multiple years are used as the base year; or b) data from sources other than the State's MMIS are used.

Step 6: See instruction box. The services noted here should be identical to those noted in the chart in Section A.III.d.1.

Step 7: **Adjustments to Base Year Service Costs:** On Appendix D.III check all adjustments that apply to base year data.

Step 8. **Fee-For-Service Wraparound Cost Adjustments**: See instruction box.

Preprint Instructions for Steps 7 and 8 above:

Required Adjustments a. through d. (below) and in Appendix D.III must be completed by all States. Optional Adjustments a. through h. (below) should be completed if the adjustment applies to your State. For each Optional Adjustment that does not apply, the State should note if a policy decision has been made to not include that adjustment. If the State has made an adjustment to its without waiver cost, information on the basis and methodology information below must be completed and mathematically accounted for in Appendix D.IV. All adjustments may be computed on a statewide basis. Similarly, some adjustments will apply to all services and to all eligibility categories while others will only apply to specific services provided to distinct eligibility categories. Again, it is very important to complete this submittal and Appendices D.III and D.IV in order to account for the proper methodology used by the State to calculate the without waiver costs.

Please note the waiver years that each adjustment was in place if the adjustment was not made for all four years. Submit separate Appendix D.IV charts for each year in the Without Waiver costs for the previous and upcoming waiver period.

Previous Waiver Period

a.___ During the last waiver period, the methodology used to calculate cost-effectiveness was different than described in the waiver governing that period. Please explain why the program operated differently and what the differences were:

Please note the date of any methodology change and explain any methodology changes in this submittal. See also Step 5.

Upcoming Waiver Period -- For all three subsets of adjustments (Without Waiver Response required, Optional, and With Waiver Cost Adjustments) in this section, please identify any responses that reflect a change in program from the previous waiver submittal by placing two asterisks (i.e., "**") after your response.

State Response to These Adjustments Is Required

a. X Copayment Adjustment: (Appendix D.III, Line 44). This adjustment accounts for any copayments that are collected under the FFS program but not collected in the waiver program. States must ensure that these copayments are included in the UPL if they will not be collected in the waiver program.

1.___ Claims data used for UPL development already included copayments and no adjustment was necessary.

2.___ State has added estimated amounts of copayments collected in FFS that will not be collected under the waiver program.

3.___ The State has chosen not to make this adjustment.

4._X_ Other (please describe):

N/A- Idaho Medicaid does not have a copayment component

b. X Incurred but not Reported (IBNR) (Appendix D.III, Line 45): Due to the lag between dates of service and dates of payment, completion factors must be applied to data to ensure that the base data represents all claims incurred during the base year. The IBNR factor increases the reported totals to an estimate of their ultimate value after all claims have been reported. Use of at least three years is recommended as a basis.
Basis:

1.___ IBNR adjustment was made. Please indicate the number of years used as basis _____.
i.___ Claims in base year data source are based on date of service.
ii.___ Claims in base year data source are based on date of payment.

2._X_ IBNR adjustment was not necessary (Please explain).

Data used for preparing FFY2000 report was extracted 18 months after the end of the period to ensure that all claims for service during the period were incorporated in the calculations.

Methodology:

1.___ Calculate average monthly completion factors and apply to the known paid total to derive an overall completion percentage for the base period.

2._X_ Other (please describe):

Data used for preparing FFY2000 report was extracted 18 months after the end of the period to ensure that all claims for service during the period were incorporated in the calculations.

c. Inflation (Appendix D.III, Line 46): This adjustment reflects the expected inflation in the FFS program between the Base Year and Year One and Two of the waiver. Inflation adjustments may be service-specific and expressed as percentage factors. States should use State historical FFS inflation rates.
Basis:

1.___ State historical inflation rates
(a) Please indicate the years on which the rates are based: Inflation base years_____
(b) Please indicate the mathematical methodology used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

2._X_ Other (please describe):

The State did not make this adjustment. Cost effectiveness calculations do not compare costs to a base year. Inflationary factors will impact both the waiver and non-waiver populations.

d. Payments / Recoupments not Processed through MMIS (Appendix D.III, Line 47): Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the without waiver costs.

1.___ Payments outside of the MMIS were made. Those payments include (please describe):

2.___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):

3._X_ The State had no recoupments/payments outside of the MMIS.

Optional Adjustments

Note: These adjustments may be made based upon the State's own policy preferences. There is no HCFA preference for any of these adjustments. If the State has made an adjustment to its without waiver cost, information on the basis and methodology used is required and must be mathematically accounted for in Appendix D.IV. If the State has chosen not to make these adjustments, please mark the appropriate box.

a. PCCM Savings Adjustment (Appendix D.III, Line 48):This adjustment is to be made when States have had a PCCM program in place for several years or when the State has had a combined MCO/PCCM program. The case management fees need to be deducted from without waiver costs.

1.___ PCCM claims data were used to create without waiver costs and management fees were deducted. Please note: if the State chose to use PCCM claims data, then this adjustment is required.

2._X_ This adjustment was not necessary because the State used MMIS claims exclusive of any PCCM case-management fees.

3.___ Other (please describe):

b. Pooling for Catastrophic Claims (Appendix D.III, Line 49): This adjustment should be used if it is determined that a small number of catastrophic claims are distorting per capita costs in some rate cells and are not predictive of future utilization.
Methodology:

1.___ The high cost cases' costs are removed from the rate cells and the per capita claim costs are distributed statewide across a relevant grouping of payment cells. No costs are removed entirely from the rate cells, merely redistributed to rate cells in a manner that is more predictive of future utilization.

2._ _ The State has chosen not to make adjustment.

3._X_ Other (please describe):

Hospital costs related to injury, pregnancy, and newborns are not included in the calculations.

c. Pricing (Appendix D.III, Line 50): These adjustments account for changes in the cost of services under FFS. For example, changes in fee schedules, changes brought about by legal action, or changes brought about by legislation.

Basis:

1.___ Expected State Medicaid FFS fee schedule increases between the base and rate periods.

2.___ Changes brought about by legal action (please describe):

3.___ Changes in legislation (please describe):

4.___ Other (please describe):

5._X_ The State has chosen not to make adjustment.

d. Programmatic/policy changes after claims extraction (Appendix D.III, Line 51): These adjustments should account for any FFS programmatic changes that are not cost neutral and affect the without waiver costs. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program.
Basis and Methodology:

1.___ The State made this adjustment (please describe).

2._X_ The State has chosen not to make adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

e. Regional Factors applied to Small Populations (Appendix D.III, Line 55): This adjustment is to be applied when there are a small number of eligible months in certain rate cells and large variations in PMPMs across these categories and regions exist.
Methodology:

1.___ Regional factors based on eligible months are developed and then applied to statewide PMPM costs in rate cells for small populations. This technique smooths out wide fluctuations in individual rate cells in

rural states and some populations, yet ensures that expenditures remain budget neutral for each region and State.

2._X_ The State has chosen not to make adjustment.

3.___ Other (please describe):

e. Utilization (Appendix D.III, Line 56): This adjustment reflects the changes in utilization of FFS services between the Base Year and the beginning of the waiver and between Years One and Two of the waiver.

1.___ The State estimated the changes in technology and/or practice patterns that would occur in FFS delivery, regardless of the waiver program. Utilization adjustments made were service-specific and expressed as percentage factors.

2._X_ The State has chosen not to make adjustment.

Cost effectiveness calculations do not reflect comparisons to a base year.

3.___ Other (please describe):

g. Other Adjustments (Appendix D.III, Line 57). If the State has made any other adjustments, please list and describe the basis and methodology:

h. Data Smoothing Calculations for Predictability (Appendix D.III, Line 59): Costs in rate cells are smoothed through a cost-neutral process to reduce distortions across cells and adjust rates toward the statewide average rate. These distortions are primarily the result of small populations, access problems in certain areas of the State, or extremely high cost catastrophic claims.

Basis and Methodology

1.___ The State made this adjustment (please describe):

2._X_ The State has chosen not to make adjustment.

Cost effectiveness calculations do not reflect comparisons to a base year.

Step 9: **With Waiver Cost Adjustments** (in addition to the without waiver or FFS Base Year Cost Adjustments), (Appendix D.III, Line 70). Note: Costs for adjustments are to be included in the With Waiver Costs Appendix D.V.

a. Incentive/bonus payments (Appendix D.III, Line 65): The amount listed here should match information provided in Section D.I. Reimbursement of Providers. This adjustment should be applied if the State elects to provide incentive payments in addition to management fees under the waiver program.

IV. Without Waiver Development (PMPM): Appendix D.IV

Purpose: To calculate without waiver costs on a PMPM basis.

NOTE: HCFA will measure the cost effectiveness of the waiver in the renewal based on this PM PM calculation and the actual enrollment under the waiver.

Please note that the data in this section for Waiver Years 1 and 2 should reflect the PMPM Without Waiver costs that were approved in the previous waiver in your renewal, plus any changes approved by the RO. Please submit separate Appendix D.IV charts for each year in the Without Waiver costs for the previous and upcoming waiver period.

Step 10: See instruction box.

Step 11: See instruction box. These rate cells must be identical to the rate cells used in **Appendix II. Member Months** .

Steps 12-13: See instruction boxes.

Step 14: See instruction box. Adjustments expressed as percentages are applied to the base year amount by category of service.

Steps 15-16: See instruction boxes.

Step 17: See instruction box. Step 17 is designed to incorporate the cost of FFS wraparound services into the without waiver costs. To simplify presentation, the State may combine all wraparound services listed at Appendix D.III, presenting them as one base year amount per rate cell. The State may then combine all adjustment factors which affect a given rate cell, and apply the adjustments accordingly. This methodology will result in a subtotal of adjusted FFS costs applied to each rate cell. If the State prefers, individual FFS wraparound services may be calculated in Appendix D.IV.

Step 18: See instruction box. These amounts represent the final PMPM amounts which will be applied to actual enrollment in measuring cost effectiveness. States will not be held accountable for caseload changes when submitting their waiver renewal cost-effectiveness calculations. States should have PMPM costs for the 4-year period equal to or less than projected Without Waiver costs as calculated in Step 18.

V. With Waiver Development: Appendix V.

Purpose: To calculate costs with the waiver on a PMPM basis. With waiver costs are the sum of payments to providers, management fees, and the costs to the State of implementing and maintaining the managed care program.

a._X_ The State assures HCFA that the costs with the waiver will be equal or less to costs without the waiver.

b. X Please explain how the State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may monitor monthy PMPM with waiver cost reports or the State may conduct periodic mock cost-effectiveness tests):

The State will conduct quarterly mock cost-effectiveness tests.

c.___ The State is requesting a 1915(b)(3) waiver in Section A. II.g.2. and will be providing non-state plan medical services.

Please state the actual amounts spent on 1915(b)(3) savings which was spent on additional services in the previous waiver period: _____. This amount must be built into the State's with waiver costs for Years 1 and 2.

Please state the PMPM or aggregate amount of 1915(b)(3) savings which will be spent on additional services in the upcoming waiver period _____. This amount must be built into the State's with waiver costs for Years 3 and 4.

d._X_ The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the with waiver calculations:

The report by the Lewin Group (see section A.II.N.2) in 2000 concluded that the Healthy Connections program did not display selection bias except possibly in the area concerning birth costs which are not included in these calculations.

Step 19-21: See instruction boxes. The eligibility categories and rate cells must agree with those in Appendix D.IV. The eligibility categories and rate cells must agree with those in Appendix D.IV. States must document actual PMPM costs under the waiver for the previous two-year period. They also must estimate the PMPM costs under the upcoming waiver period. **Please note that the data in this section for Waiver Years 1 and 2 should reflect the actual costs incurred in the previous waiver period under the Waiver Program. Please submit separate Appendix D.IV charts for each year in the Without Waiver costs for the previous and upcoming waiver period.** Note: because of the timing of the waiver renewal submittal, the State may need to estimate up to six (6) months of enrollment data for Year 2 of the previous waiver period.

Step 22: Include any cost savings that will result from the waiver.
Step 23: See instruction box
Step 24: See instruction box.
Step 25: See instruction box. Any case management fees to be paid must be included in the Total Waiver Program Costs. The case management fees must match those listed in D.I. Reimbursement of Providers.
Step 26: List and include all waiver administrative costs. Please describe below any unusal contracts entered into as part of the waiver program or the absence of any expected costs (such as, systems modification, enrollment broker, consultant, independent assessment, utilization review system, quality assurance review system, contract administration, additional staff, hotline operation):
Steps 27-29: See instruction boxes.

VI. Year 1 Aggregate Costs: Appendix D.VI
See Instructions for C.VII Year 2 Aggregate Costs

VII. Year 2 Aggregate Costs : **Appendix D.VII**
Steps 30-35: See instruction boxes.

VIII. Year 3 Aggregate Costs : **Appendix D.VIII**
See Instructions for C.VII Year 2 Aggregate Costs

IX. Year 2 Aggregate Costs : **Appendix D.IX**
See Instructions for C.VII Year 2 Aggregate Costs

X. Cost Effectiveness Summary: Appendix D.X
Steps 36-40: See instruction boxes.

Section E. Fraud and Abuse

States can promote the prevention, detection, and reporting of fraud and abuse in managed care by ensuring both the State and the PCCMs have certain provisions in place. Please check all items below which apply, and describe any other measures the State takes.

Previous Waiver Period

a.___ During the last waiver period, the program's fraud and abuse requirements operated differently than described in the waiver governing that period. Please explain why the program operated differently and what the differences were:

b. [Required for all elements checked in the previous waiver submittal] Please provide summary results from all fraud and abuse monitoring activities, including a summary of any analysis and corrective action taken, for the previous waiver period [items E.I-II of 1999 initial application; relevant sections of 1996 submittal].

Upcoming Waiver Period -- Please check all items below which apply, and describe any other measures the State takes. For all items in this section, please identify any responses that reflect a change in program from the previous waiver submittal by placing two asterisks (i.e., "**") after your response.

I. State Mechanisms

a._X_ The State has systems to avoid paying for unauthorized services (e.g., denial of claims for services which must have the referral of the primary care case manager).

b.___ The State has in place a formal plan for preventing, detecting, pursuing, and reporting fraud and abuse in the managed care program in this waiver, which identifies the staff, systems, and other resources devoted to this effort. Please attach the fraud and abuse plan.

c.___ The State has a specific process for informing primary care case managers of fraud and abuse requirements under this waiver. If so, please describe.

d._X_ Other (please describe):

The State's Fraud & SUR/S Unit is responsible for monitoring fraud and abuse in/of the Medicaid program as a whole, which includes the managed care

component .

II. Primary Care Case Manager Provision

a._X_ The State requires primary care case managers to report suspected fraud and cooperate with State (including Medicaid Fraud Control Unit) investigations.

Section F. Special Populations

States may wish to refer to the October 1998 HCFA document entitled “Key Approaches To The Use of Managed Care Systems For Persons With Special Health Care Needs” as guidance for efforts to ensure access and availability of services for persons with special needs. To a certain extent, key elements of that guide have been incorporated into this waiver application form.

I. General Provisions for Special Populations

Previous Waiver Period

a.___ During the last waiver period, the program operated differently for special populations than described in the waiver governing that period. Please explain why the program operated differently and what the differences were:

b. [Required for all elements of applicable sections checked in the previous waiver submittal] Please provide results from all monitoring efforts for each subpopulation noted in the previous waiver, including a summary of any analysis and corrective action taken, to determine the level of compliance with State requirements in the area of Special Populations for the previous waiver period [items F.I.a-g of the 1999 initial application; as applicable in 1996 submittal].

c. Please describe the transition plan for situations where an enrollee with special health care needs will be assigned to a new provider when the current provider is not included in the provider network under the waiver.

Upcoming Waiver Period -- For items a. through g. of this section, please identify any responses that reflect a change in program from the previous waiver submittal by placing two asterisks (i.e., "**") after your response. Please check all items which apply to the State.

a._X_ The State has a specific definition of “special populations” or “populations with special health care needs.” The definition should include populations beyond those who are SSI or SSI-related, if appropriate, such as persons with serious and persistent mental illness, and should specify whether they include adults and/or children. Some examples include: Children with special needs due to physical and/ or mental illnesses, Older adults (over 65), Foster care children, Homeless individuals, Individuals with serious and persistent mental illness and/or substance abuse, Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or other. Please describe.

Children with special needs are defined at IDAPA 116.02.26 (available at http://www2.state.id.us/adm/adminrules/rules/idapa16/0226.pdf) and include children with the following:

- Cardiac (congenital heart disease/defects, etc)
- Cleft Lip & Palate
- Craniofacial (congenital anomalies)
- Cystic Fibrosis
- Neurologic (CP, epilepsy, etc)
- Orthopedic (juvenile RA, etc)
- PKU
- Plastic/Burn (hemangioma)

b._X_ There are special populations included in this waiver program. Please list the populations.

Children with special health care needs (as defined above) that have Medicaid coverage.

c.___ The State has developed and implemented processes to collaborate and coordinate with, on an ongoing basis, agencies which serve special needs clients, advocates for special needs populations, special needs beneficiaries and their families. If checked, please briefly describe.

d.___ The State has programs/services in place which coordinate and offer additional resources and processes to ensure coordination of care among:

1.___ Other systems of care (Please specify, e.g. Medicare, HRSA Title V grants, Ryan White CARE Act, SAMHSA Mental Health and Substance Abuse Block Grant Funds)
2.___ State/local funding sources
3.___ Other (please describe):

e._X_ The State has in place a process for ongoing monitoring of its listed special populations ~~by special needs subpopulation~~ included in the waiver in the following areas:

1._ _ Access to services (please describe):
2.___ Quality of Care (please describe):
3._ _ Coordination of care (please describe):
4._X_ Enrollee satisfaction (please describe):

Annual client survey

5.___ Other (please describe):

f.___ The State has standards or efforts under way regarding a location's physical Americans with Disabilities Act (ADA) access compliance for enrollees with physical disabilities. Please briefly describe these efforts, and how often compliance is monitored.

g.___ The State has specific performance measures and performance improvement projects for their populations with special health care needs. Please identify the measures and improvement projects by each population. Please list or attach the standard performance measures and performance improvement projects:

II. State Mechanisms for Providers

Previous Waiver Period

a.___ During the last waiver period, the program operated differently for special populations than described in the waiver governing that period. Please explain why the program operated differently and what the differences were:

b. X [Required for all elements checked in the previous waiver submittal] Please provide results from all monitoring efforts for each subpopulation noted in the previous waiver, including a summary of any analysis and corrective action taken, to determine the level of compliance with State requirements in the area of Special Populations for the previous waiver period [items F.II.a-h of the 1999 initial application; as applicable in 1996 submittal].

Upcoming Waiver Period For items a. through h. of this section, please identify any responses that reflect a change in program from the previous waiver submittal by placing two asterisks (i.e., "**") after your response. Please check all the items which apply to the State or PCCMs.

a._X_ The State has ~~required~~ case management services which shall be available for individuals with special health care needs. Please describe these services and whether or not the State requires a primary care case manager referral to access these services.

Targeted case management services are those that assist the Medicaid child and their family to obtain and coordinate needed health, educational, early intervention, advocacy, and social services identified in an authorized SC plan

developed by the Department or their contractor and require referral from the PCP.

b.___ As part of its criteria for contracting with primary care case managers, the State assesses the primary care case manager's skill and experience level in accommodating people with special needs. Please describe by population.

c.___ The State makes efforts to secure arrangements with providers who have traditionally served people with special needs, for example, Ryan White providers and agencies which provide care to homeless individuals. If checked, please describe by population.

d._X_ The State has provisions which allow beneficiaries who utilize specialists frequently for their health care to be allowed to maintain these types of specialists as primary care case managers. If **not** checked, please explain by population.

e.___ The State collects population-specific data for special populations. Please describe by population.

f.___ The State has a unique services marked in the table in Section A.III.d.1 that are for special needs populations only. Please note by population.

g.___ The State identifies or requires primary care case managers to identify individuals with complex or serious medical conditions in the following ways:

1.___ An initial and/or ongoing assessment of those conditions
2.___ The identification of medical procedures to address and/or monitor the condition
3.___ A treatment plan appropriate to those conditions that specifies an adequate number of direct access visits to specialists to accommodate implementation of the treatment plan.
4.___ Other (please describe):

h.___ The State specifies requirements of the primary care case managers for the special populations in the waiver that differ from those requirements described in previous sections and earlier in this section of the application. Please describe by population.

g. X Other: The State allows potential special needs participants to be exempt from participation should they have an established relationship with a non-participating PCP.

Section G. Complaints, Grievances, and Fair Hearings

States are required to provide Medicaid enrollees with access to the State Fair Hearing process as required under 42 CFR 431 Subpart E, including:

- informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
- ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
- other requirements for fair hearings found in Subpart E.

States, at their option, may have a PCCM grievance procedure (distinct from the fair hearings process) administered by or for the State agency that provides for prompt resolution of issues. Please note: these grievance procedures are strictly voluntary.

I. Definitions:

Previous Waiver Period

a.___ During the last waiver period, complaints, grievances, and State Fair Hearings operated differently than described in the waiver governing that period. Please explain why the program operated differently and what the differences were:

Upcoming Waiver Period -- Please identify any responses that reflect a change in program from the previous waiver submittal by placing two asterisks (i.e., "**") after your response.

a. X Please provide definitions for terms like appeal, grievance or complaint used by the State for State Fair Hearings or PCCM grievance procedures.

- Appeal: Written request for reconsideration of services denied by the Medicaid agency
- Grievance: Written request for reconsideration of application of any aspect of the managed care program that has produced a perceived negative impact to the participant (i.e. denial of referral, denial of payment due to lack of referral, access, etc)
- Complaint: Verbal (via phone) accusations of perceived negative circumstances regarding participation in the managed care program

b. Please describe any special processes that the State has for persons with special needs.

II. State Requirements and State Monitoring Activities:

Previous Waiver Period

a.___ During the last waiver period, the program operated differently than described in the waiver governing that period. Please explain why the program operated differently and what the differences were:

b. X [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts, including a summary of any analysis and corrective action taken with respect to complaints, grievances and fair hearings for the previous waiver period [items G.II.a and G.II.b of the 1999 initial application; as applicable in 1996 submittal]. Also, please provide summary information on the types of complaints, grievances or fair hearings during the previous two-year period following this addendum. Please note how access and quality of care concerns were addressed in the State's Quality Improvement Strategy.

c. Please mark any of the following that apply:

1._X_ A hotline was maintained which handles any type of inquiry, complaint, problem or State Fair Hearing request.

2._X_ Following this section is a list or chart of the number and types of complaints, grievances, and/or State Fair Hearings handled during the waiver period.

3.__ There is consumer involvement in the PCCM grievance process. Please describe.

Upcoming Waiver Period -- For items a. and b. of this section, please identify any responses that reflect a change in program from the previous waiver submittal by placing two asterisks (i.e., "**") after your response. Please check any State requirements in effect for State Fair Hearing processes.

I. Definitions:

a. Please provide definitions for terms like appeal, grievance or complaint used by the State for State Fair Hearings or PCCM grievance procedures.

- Appeal: Written request for reconsideration of services denied by the Medicaid agency

- Grievance: Written request for reconsideration of application of any aspect of the managed care program that has produced a perceived negative impact to the participant (i.e. denial of referral, denial of payment due to lack of referral, access, etc)
- Complaint: Verbal (via phone) accusations of perceived negative circumstances regarding participation in the managed care program

b. Please describe any special processes that the State has for persons with special needs.

II. State Requirements and State Monitoring Activities: Please check any State requirements in effect for State Fair Hearing processes.

a. Required Fair Hearings Elements: If any required items below are not checked, please explain.

1._X_ A PCCM enrollee can request a State Fair Hearing for reductions, terminations and suspensions of Medicaid covered services under the State's Fair Hearing process. Please explain how, under what circumstances, and when an enrollee can access the State Fair Hearing process

A Fair Hearing can be requested by a participant:
- at any time
- in the same manner and circumstances as non-participants
- when the participant has been denied services by the Medicaid agency
- by submitting a Fair Hearing request form

2._X_ Enrollees are informed about their fair hearing rights at the time of Medicaid eligibility determination and at the time of any action as defined in 42 C.F.R. 431 Subpart E.

3._X_ The State ensures that enrollees may request continuation of benefits or reinstatement of services during a course of treatment during a fair hearing appeal. The State informs enrollees of the procedures by which benefits can be continued or reinstated

4._X_ Enrollees are informed about their fair hearing rights at the time of PCCM enrollment and/or on a periodic basis thereafter. Please specify how and through what means enrollees are informed.

Fair hearing information is being added to the enrollment form that will be used under the waiver**

b. Optional Complaints, Grievances, and Fair Hearings Elements:

1._X_ The State has a grievance procedure characterized by the following (please check any of the following optional procedures that apply to the State's optional PCCM grievance procedure):

(a)_X Has a grievance committee or staff who review and resolve complaints and grievances. Please describe If the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM adminstrator function:

Grievances are reviewed and responded to by the Program Manager in the central business office.

(b)_X Reviews requests for reconsideration of initial decisions not to provide or pay for a service.

(c)_X Specifies a time frame from the date of action for the enrollee to request a grievance resolution or fair hearing. Specify the time frame _____

(d)_X Has time frames for staff to resolve grievances for PCCM grievances. Specify the time frame set _30 days___

(e)__ Establishes and maintains an expedited grievance review process for the following reasons:_____ Specify the time frame set by the State for this process____

(f)__ Permits enrollees to appear before PCCM personnel responsible for resolving the grievance.

(g)__ Provides that, if the grievance decision is adverse to the enrollee, the grievance decision and any supporting documentation is forwarded to the State Fair Hearing within a time frame specified by the State. Specify the time frame____.

(h)__ The State acknowledges receipt of each complaint and grievance when received and explains to the enrollee the process to be followed in resolving his or her issue. If the State has a time frame for PCCM staff to acknowledge complaints and grievances, please specify:

(i)_X Gives enrollees assistance completing forms or other assistance necessary in filing complaints or grievances (or as complaints and grievances are being resolved).

(j)_X Conducts grievance resolution/hearings using impartial individuals not involved in previous levels of decision making.

(k)_X** If the focus of the grievance is a denial based on lack of medical necessity, one of the reviewers is a physician with appropriate expertise in the field of medicine that encompasses the enrollee's condition or disease.

(l)_X Bases the State's decision on the record of the case.

(m)_X Notifies the enrollee in writing of the grievance decision and further opportunities for appeal, as well as the procedures available to challenge or appeal the decision.

(n)__ Upon request, provides enrollees and potential enrollees with aggregate information regarding the nature of enrollee complaints and grievances and their resolution.

(o)__ Sets time frames for the State to authorize or provide a service if the decision is overturned or reversed through the grievance or fair hearing process. Specify the time frame____

(p)_X Informs the enrollee of any applicable mechanism for resolving the issue external to the PCCM's own processes.

(q)__ Determines whether the issue is to be resolved through the grievance process, the process for making initial determinations on coverage and payment, or the process for resolution of disputed initial determinations.

(r)__ Other (please explain):

2._X_ The State maintains a log of all ~~complaints and~~ grievances and their resolution.

A system to log and track complaints is currently under development and will be implemented under the waiver.**

3._X_ The State compiles a summary of ~~complaints and~~ grievances on at least an annual basis.

- In 2000, there were 8 grievances and 2 of these were denied. There were no fair hearings.
- In 2001, there were 10 grievances and 3 of these were denied. There were no fair hearings.

4.___ The State maintains, aggregates, and analyzes information on the nature of issues raised by enrollees and on their resolution. Please note if the State maintains information on the demographic background of enrollees raising these issues.

5.___ The State conducts in-depth reviews of providers or services identified through summary reports as having undesirable trends in complaints and grievances.

6.___ The State has an ombudsprogram to assist enrollees in the complaint, grievance, and fair hearing process.

7.___ Other (please specify):

Section H. Enrollee Information and Rights

This section describes the process for informing enrollees and potential enrollees about the waiver program, and protecting their rights once enrolled. The information in this section (e.g., enrollee handbooks, enrollment information, PCCM choice materials) is considered to be marketing material because it is sent directly to enrollees. However, the traditional marketing materials (e.g., billboards, direct mail, television and radio advertising) are addressed above in Section A (see A.III.a).

I. Enrollee Information - Understandable to Enrollees:

Previous Waiver Period

a.___ During the last waiver period, the requirements for understandable enrollee information operated differently than described in the waiver governing that period. Please explain why the program operated differently and what the differences were:

b. X [Required] Please provide copies of the brochure and informational materials explaining the program and how to enroll.

Upcoming Waiver Period -- This section describes how the State ensures information about the waiver program is understandable to enrollees and potential enrollees. Please check all the items which apply to the State or PCCM. For all items in this section, please identify any responses that reflect a change in program from the previous waiver submittal by placing two asterisks (i.e., "**") after your response. Items which are required have "[Required]" in front of them. Checking a required item affirms the State's intent to comply. If the State does not check a required item, please explain why.

a._X_ [Required] The State will ensure that enrollee materials provided to enrollees by the State and the enrollment broker are clear and easily understandable.

b._X Enrollee materials will be translated into the languages listed below (If the State does not translate enrollee materials, please explain):

Spanish

The State has chosen these languages because (check any that apply):

1.___ The languages comprise all prevalent languages in the PCCM service area. Please describe the methodology for determining prevalent languages.

2._X_ The languages comprise all languages in the PCCM service area spoken by approximately _10__ percent or more of the population.
3.___ Other (please explain):

c._X_ Program information is available and understandable to non-English speaking enrollees whose language needs are not met through the provision of translated material described above. Please describe.

AT&T Language Line services are used by program staff to communicate with non-English speaking enrolless.

d._X_ [Required] Translation services are available to all enrollees, regardless of languages.

e._X_ Every new enrollee will have access to a toll-free number to call for questions. Please note if the State requires TTY/TDD for those with hearing/speech impairments.

Idaho Relay Service provides TTY/TDD for communication between clients and program.

f.__ Enrollee materials are available in alternative formats (e.g., for low literacy individuals or for the visually impaired). Please describe.

II. Enrollee Information - Content

Previous Waiver Period

a.___ During the last waiver period, the enrollee information requirements operated differently than described in the waiver governing that period. Please explain why the program operated differently and what the differences were:

Upcoming Waiver Period -- This section describes the types of information given to enrollees and potential enrollees. Please check all that apply. For all items in this section, please identify any responses that reflect a change in program from the previous waiver submittal by placing two asterisks (i.e., "**") after your response. Items which are required have "[Required]" in front of them. Checking a required item affirms the State's intent to comply. If a required item is not check, please explain why.

a. Information provided by the State and/or its Enrollment Broker. The State and/or its enrollment broker provides the following information to enrollees and potential enrollees.

1.___ Every new enrollee will be given a brief in-person presentation describing how to appropriately access services under the managed care system and advising them of enrollees' rights and responsibilities.

2._X_ An initial notification letter.

3._X_ Informational materials describing how to appropriately access services under the managed care system and advising them of enrollees' rights and responsibilities.

4._X_ A form for enrollment in the waiver program and selection of a primary care case manager.

5._X_ A list of primary care case managers serving the enrollee's geographical area, including information about which providers are accepting new Medicaid enrollees and any restrictions on enrollees' ability to select from among primary care case managers.

This is currently only done in mandatory counties due to State law restrictions on publishing lists of providers. In voluntary counties, clients who wish to enroll but do not have a PCP can contact the local HRC to receive this information verbally.

6.___ Comparative information on primary care case managers.

7._X_ Information on how to obtain counseling on choice of primary care case managers.

8.___ Detailed provider network listings (of members of group practices, if the practice as a whole can enroll as a single entity). Please note if this information contains specialized information such as listing the providers who have staff who can provide assistance in making appointments or translating during medical visits (i.e., the array of services available in FQHCs).

9.___ A new Medicaid card which includes the PCCM's name and telephone number or a sticker noting the primary care case manager's name and telephone number to be attached to the original Medicaid card (please specify which method).

10.__ A health risk assessment form to identify conditions requiring immediate attention.

11.__ Information concerning the availability of special services, expertise, and experience offered by primary care case managers.

12._X [Required] Information explaining the grievance procedures and how to exercise due process rights and their fair hearing rights.

13.__ [Required for PCCMs with lock-in periods] Information about their right to disenroll without cause the first 90 days of each enrollment period. (See A.III.b.5)

14._X Information on how to obtain services not authorized by the primary care case manager but covered under the State plan.

15.__ [Required for PCCM programs with lock-in periods] For enrollees in lock-in period, notification 60 days prior to end of enrollment period of right to change PCCMs (See A.III.b.5)

16._X [Required] Procedures for obtaining primary care services from the primary care case manager.

17._X [Required] After-hours and emergency coverage, including:

(i)___ definition of emergency services
(ii)__ the prudent layperson definition of emergency medical condition [please note: that the State may modify the BBA statutory language to make it more easily understood].
(iii)__ the prohibition on retrospective denials for services that meet the prudent layperson definition (e.g. to treat what appeared to the enrollee to be an emergency medical condition at the time the enrollee presents at an emergency room)
(iv)_X the right to access emergency services without prior authorization.

18.__ Procedures for obtaining non-covered or out-of-area services.

19.__ Any special conditions or charges that may apply to obtaining services.

20._X [Required] The right to obtain family planning services from any

Medicaid-participating provider.

21._X [Required] Procedures for obtaining referrals for specialty care and other services requiring authorization but not furnished by the enrollee's primary care case manager.

22._ [Required] Charges to enrollees, if applicable.

N/A

23._X [Required] Procedures for changing primary care providers, including the ability to disenroll/transfer for cause at anytime (if PCCM program has a lock-in provision).

24.__ Procedures for obtaining mental health, substance abuse, and developmental disability services

25.__ Notification of termination or changes in benefits, services, service sites, or affiliated providers (if the enrollee is affected). Notices are provided in a timely manner.

26.__ A description of new technology for inclusion of a covered benefit.

27.__ Procedures for obtaining services to which an enrollee can self-refer (see Section A.III.d.1).

28._X Instructions on how to obtain information in languages other than English.

All program materials and notifications (for client use) include the phone number to call for help En Espanol.

29.__ Instructions on how to obtain translation services.

30.__ Instructions on how to obtain information in alternative formats (e.g., for low literacy individuals or for the visually impaired).

31.__ Other (please describe):

b.__ Information provided by the primary care case manager -- The State requires the primary care case manager and or provider's office to provide enrollees with information on how to challenge or appeal the failure of the primary care case manager to authorize an item or service.

III. Enrollee Rights:

Previous Waiver Period

a.___ During the last waiver period, the requirements for enrollee rights operated differently than described in the waiver governing that period. Please explain why the program operated differently and what the differences were:

Upcoming Waiver Period -- For items a. through n. of this section, please identify any responses that reflect a change in program from the previous waiver submittal by placing two asterisks (i.e., "**") after your response. Please check any of the processes and procedures in the following list the State uses to ensure that enrollee rights are protected in the PCCM program.

a._X_ Have written policies with respect to enrollee rights.

b._X_ Communicate policies to enrollees, staff and providers.

c.___ Monitor and promote compliance with their policies by staff and providers.

d._X_ Ensure compliance with Federal and State laws affecting the rights of enrollees such as all Civil Rights and anti-discrimination laws.

e.___ Implement procedures to ensure the confidentiality of health and medical records and of other information about enrollees.

f._X_ Implement procedures to ensure that enrollees are not discriminated against in the delivery of medically necessary services.

g.___ Ensure that all services, both clinical and non-clinical, are accessible to all enrollees, including special populations.

h._X_ Ensure that each enrollee may select his or her primary care provider from among those accepting new Medicaid enrollees.

i._X_ Ensure that each enrollee has the right to refuse care from specific providers.

j._X_ Have specific written policies and procedures that allow enrollees to have access to his or her medical records in accordance with applicable Federal and State laws.

k.___ Have specific written policies that allow enrollees to receive information on

available treatment options or alternative courses of care, regardless of whether or not they are a covered benefit.

l.__ Allow direct access to specialists for beneficiaries with long-term or chronic care needs (e.g., severely and persistently mentally ill adults or severely emotionally disturbed children)

m.__ Other (please describe):

IV. Monitoring Compliance with Enrollee Information and Enrollee Rights

Please check any of the processes and procedures the State uses to monitor compliance with its requirements for enrollee information and rights.

Previous Waiver Period

a.___ During the last waiver period, monitoring compliance with enrollee information and rights operated differently than described in the waiver governing that period. Please explain why the program operated differently and what the differences were:

b. [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring enrollee information and rights in the previous two year period, including a summary of any analysis and corrective action taken [items H.IV.a-d of 1999 initial application; items III.A.2-3 of 1996 submittal]**.**

Upcoming Waiver Period -- For items a. through d. of this section, please identify any responses that reflect a change in program from the previous waiver submittal by placing two asterisks (i.e., "**") after your response. Please check any of the processes and procedures in the following list the State uses to monitor compliance with its requirements for enrollee information and rights.

a._X_ The State tracks disenrollments and reasons for disenrollments.

b._X_ The State will approve primary care case manager-developed enrollee information prior to its release by the primary care case manager.

Only state developed materials are permissable.

c._X_ The State will monitor primary care case manager enrollee materials for compliance in the following manner (please describe):

This will be monitored by the HRCs as established in complaints received from clients or other parties and violations reported to the Program Manager.

Additionally, a question will be added to the client survey to address inappropriate marketing practices.

d._X The State will monitor the primary care case managers compliance with the enrollee rights provisions in the following manner (please describe):

This will be monitored by the HRCs as established in complaints received from clients or other parties and violations reported to the Program Manager. Additionally, a question will be added to the client survey to address violations of enrollees rights.

e.__ Other. Please explain.

Appendix A- Client Surveys

Excel Files:

- Survey_Summary_2000
- HC 2001 Nov Survey Results

Appendix B- Reasons for Change in Enrollment Summary

Excel File: Disenrollment Report 2002

Appendix C- Tribal Notification of Waiver Renewal

November 15, 2001

To: Tribal Leaders in the State of Idaho

From: Robin Pewtress, Healthy Connections, Division of Medicaid

The following is informal notification of Idaho Medicaid's intent to renew its 1915(b) Freedom of Choice waiver, operationally known as the Healthy Connections program. We would like to give you the opportunity to discuss the proposed formal notification (prior to mailing) with our representative, Pam Mason at the quarterly meeting being held November 16th at Fort Hall.

The proposed wording of the formal notification is as follows:

Idaho's Medicaid program wishes to notify the Tribal Governments of its intent to renew its 1915(b) Freedom of Choice waiver, operationally known as the Healthy Connections program, pursuant to State Medicaid Director Letter #01-024 issued by the Centers for Medicare and Medicaid Services (CMS). This waiver is due to expire February 9, 2002.

Medicaid has recently submitted a request to CMS to extend the waiver for an additional 90 days, in order to allow time for Tribal input. Additionally, we would like to have a discussion on waivers added as a standing agenda item for the quarterly meetings between Idaho Medicaid and the Tribes.

Healthy Connections is Idaho Medicaid's coordinated care program, where Medicaid recipients are encouraged to choose a primary care provider (PCP) to receive most of their medical services from. The PCP makes referrals to other health care providers as medically necessary. This arrangement creates a "medical home" for the participants.

The waiver renewal for this program is not anticipated to contain any substantive changes to the current program's operations other than to expand to the remaining 5 counties in the state (none of which have a Tribal clinic) where Healthy Connections does not operate. Currently, all the Tribal clinics in the state participate in the program as PCPs. A Tribal member can choose to enroll either with their local IHS clinic or with another PCP. If the latter is chosen, the program does not require a referral for the member to receive services at the IHS clinic. Medicaid will not be requesting a change regarding this policy.

Medicaid is currently in the process of expanding the Healthy Connections program to a mandatory status in more counties. Currently, Benewah is the only county where Medicaid recipients are assigned to a PCP if they do not choose one. If another county with an IHS clinic becomes targeted by Medicaid for mandatory status, Medicaid will be working closely with the PCPs in the county to develop operational protocol with the affected Tribe. The first criteria for a county to be moved to mandatory is that the PCPs in the county are willing to pursue in this direction.

In conjunction with program expansion, we are currently in the process of revamping our program materials. This includes a modified contract, improved patient and provider educational materials, and additional opportunities to receive program training.

If you have questions or comments regarding this waiver renewal, we encourage you to send them in writing at your earliest convenience (and prior to January 1, 2002) to:

Robin Pewtress, Alternative Care Coordinator
Department of Health & Welfare
Divison of Medicaid- Americana Terrace
P.O. Box 83720
Boise, ID 83720-0036

You may also contact Ms. Pewtress via e-mail at pewtresr@idhw.state.id.us or call her at (208) 364-1892.

RP/rp

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RP/rp

Appendix D- Cost Effectiveness Summary

Excel File: CE Waiver Renewal

Appendix E- Enrollment Materials

Brochure
Enrollment Form